

CDRSN/PHP POLICY AND PROCEDURE MANUAL		Chapter:	2.2.1
Title:	MANAGED CARE SERVICES	Page:	1 of 4
		Date Effective:	July 1, 2002
Subject:	EVALUATION FOR COVERED SERVICES	Date Revised:	August 17, 2011
		Authorizing Signature:	

AUTHORITY: WAC 388-865-0420, Intake Evaluation
CDRSN/PHP Provider Contract

SCOPE: This policy applies to Chelan-Douglas Regional Support Network/Prepaid Health Plan (CDRSN/PHP) and its contractors (agencies/providers), and subcontractors (referred to as contractors or agencies or providers throughout this policy).

PURPOSE: To ensure that intake and evaluation services for Medicaid enrollees requesting mental health services are provided in accordance with Access to Care Standards and other applicable state and federal regulations.

DEFINITIONS: Request for mental health services: A point in time when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request.

PROCEDURE:

- A. Ensuring consumer choice:
 1. RSN will contract with multiple Community Service Providers to ensure that enrollees have a choice of accessible programs.
 2. Community Service Providers will be dispersed throughout the community to ensure that a provider is available within a 90-minute commute of the consumer.

- B. Service availability:
 1. The Contractor shall provide intake evaluations and all other medically necessary mental health services.
 2. Community Service providers will have policies and procedures in place that determine how the availability of services will be provided.
 3. Intake assessment shall be completed, whenever possible, at a location of the consumers choosing.

- C. Access to services:

1. Providers must provide an intake evaluation consistent with WAC 388-865-0420 that is culturally competent and age appropriate.
2. Routine services may begin before the completion of the intake once medical necessity is established (see Medical Necessity Policy).
3. Intake and evaluation is provided by a mental health professional.
4. Intake evaluations occur within the context of the consumer's community, culture and value system and shall be culturally competent and take into consideration the specialized needs (including but not limited to; developmental disabilities, homelessness, learning disabilities, drug/alcohol abuse, limited English proficiency, physical disabilities) of the consumer.
5. Intake evaluation is utilized to:
 - a. Determine medical necessity;
 - b. Determine needs, preferences and goals;
 - c. Determine level of care (brief intervention services or community support services);
 - d. Make treatment recommendations in accordance with the Medicaid enrollees preferences;
 - e. Determine whether specialized services are indicated and arrange for consultation or referrals both in and out of network in accordance with the CDRSN provider contract.
 - f. Assess for referral or service coordination needs with other systems of care and/or primary care.
 - g. Identify those consumers who may benefit from an Individualized and Tailored Care planning process (Policy and Procedure 2.2.1); and
 - h. Initiate an individualized service plan
6. Evaluation of progress and reassessment shall be completed at least every 180 days which considers a-g above and up-dates the individual service plan accordingly.

D. Timeliness of services:

1. A routine intake evaluation must be initiated within 10 working days of the request for mental health services.
2. An intake evaluation must be completed within 24 hours of an urgent request for mental health services.
3. Intake evaluations are completed within fourteen (14) calendar days and determine medical necessity as defined in the Access to Care Standards.

4. Intakes not completed within fourteen (14) calendar days will include documentation regarding the reason why the intake evaluation was not completed in accordance with the established timeline.
5. Offer routine mental health services within fourteen (14) calendar days of establishing medical necessity for treatment. Routine services may begin before the completion of the intake once medical necessity is established.
6. Bring services to the enrollee or locate services at sites where transportation is available to enrollees.
7. Ensure for those services that occur in the office an enrollee should not have to wait for over an hour beyond their scheduled appointment time.
8. Ensure that when enrollees must travel to service sites, the sites are accessible per the following standards:
 - In rural areas, service sites are within a 30-minute commute time;
 - In large rural geographic areas, service sites are accessible within a 90-minute commute time;
 - In urban areas, service sites are accessible by public transportation with the total trip, including transfers, scheduled not to exceed 90-minutes each way;
9. Travel standards do not apply: a) when the enrollee chooses to use service sites that require travel beyond the travel standards; b) to psychiatric inpatient services; c) under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

E. Service Authorizations:

1. Service Authorizations will be made according to the Authorization for Services Policy.

SEE ALSO: Chapter 2.1, Medical Necessity--Level One and Level Two Criteria
Chapter 2.3, Special Populations Assessment and Ongoing Consultation

Chapter 2.4, Brief Intervention Services
Chapter 2.5, Community Support Services
Glossary of Terms and Acronyms