

CDRSN/PIHP POLICY AND PROCEDURE MANUAL		Chapter:	2.7
Title:	MANAGED CARE SERVICES	Page:	1 of 11
		Date Effective:	July 1, 2002
Subject:	SERVICE LEVEL DETERMINATION AND AUTHORIZATION AND COVERAGE OF SERVICES	Date Revised:	August 8, 2005
		Authorizing Signature:	

**AUTHORITY:** Guiding Principle(s): Consumer Focused, Holistic/Humanitarian, Responsive, Effectively Managed  
WAC 388-865-0225, Resource Management  
RCW 71.24.025, Community Mental Health Services Act, Definitions  
DSHS Standard Work Order, RSN/PIHP Services  
DSHS Title XIX Contract and Federal Waiver  
42 CFR 438.210(b)(1)(2)(3);(c);(d)(1)(2);(e)  
42 CFR 438.114(a)(1)(2)(3); (b)(1); (c)(1); (d)(1)(2)(3); (e); (f)  
42 CFR 422.208(referenced within)  
State MHD Quality Strategy Doc Sec IV  
State Access to Care Guidelines  
State MHD Q&A Doc 4/26/04  
State MHD Exhibit E of the RSN Contract 2003-2005, "Memorandum #: 01-03 MAA";

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

**PURPOSE:** This policy ensures individuals receive appropriate levels of care and maximizes access to and use of mental health services.

**DEFINITIONS:** "Sub-contractor" means" : An individual or entity performing all or part of the services under the RSN Contract 2003-2005 under a separate contract with the RSN or its sub-contractors.

"Consumer" means: A person who is now or has in the past received mental health services.

"Enrollee" means: A Medicaid recipient who is currently enrolled in CDRSN/PIHP.

"Complaint" means: A verbal or written statement by an enrollee that expresses dissatisfaction with some aspect of services, his/her provider, or the CDRSN/PIHP.

“Inpatient” means: A person who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.

“Length of stay (LOS)” means: The number of days that a covered person stayed in an inpatient facility.

“Authorization” means: When a Medicaid enrollee meets the Access to Care standards they are automatically authorized for outpatient services.

“Prior-authorization” means: The process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

“Action” means: A decision by the prepaid inpatient health plan regarding:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as defined by the state;
5. The failure of a prepaid inpatient health plan to act within the timeframes provided in section 42 CFR 438(b).

“Appeal” means: A formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment or an administrative action, with the goal of finding a mutually acceptable solution. Another definition: A request for review of an action as “action” is defined above.

“Grievance” means: A written request by an enrollee that a complaint be heard and adjudicated by the CDRSN/PIHP appropriate committee, usually undertaken after attempted resolution of a complaint fails.

“Fair Hearing” means: A grievance hearing before the Washington State Office of Administrative Hearings.

“Medical Necessity” refers to: 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

physical deformity or malfunctions, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. (King Co. definition)(WAC 388-865-0150) NOTE: See also the Quality Strategy Document for definition of “medical necessity.”

“Screening” means: The process by which a provider evaluates persons who present for service and determines the appropriate service referral.

POLICY: OUTPATIENT CARE

The CDRSN/PIHP process for authorization of outpatient care follows State of Washington MHD rules based on the CMS waiver term and condition on ‘authorization’ into services, and it is as follows:

1. All Medicaid eligibles are enrolled into the CDRSN/PIHP.
2. Therefore, all Medicaid eligibles are entitled to the mental health benefit.
3. If a Medicaid eligible meets the State Access to Care Guidelines and meets medical necessity they are then authorized into service. All authorizations for outpatient services are made by a Mental Health Professional.
4. Once a Medicaid eligible is authorized for service, the CDRSN/PIHP must have an approved Level of Care that is provided to the Medicaid eligible.

The CDRSN/PIHP has an internal authorization process functioning to meet the framework of decision making outlined in the steps above. The CDRSN/PIHP has up to date policies and procedures which govern how the CDRSN/PIHP performs these functions above

In the event that the CDRSN/PIHP delegates the function of authorization—inpatient or outpatient-- to a sub-contractor, the sub-contractor is responsible for this function, with the CDRSN/PIHP retaining authority and oversight duties. Both entities in this delegation have appropriate and sufficient policies and procedures that govern how they perform their respective roles in these authorization and oversight processes. The policies and procedures which govern how these functions are performed cover initial authorization into service, concurrent review, and authorization extension.

The policies and procedures for authorization and coverage determination address four key functions listed below:

1. Authorization of Services
2. Notice of Adverse Action
3. Timeframes for Decision Making

#### 4. Compensation for Utilization Management

Authorization of Services: The CDRSN/PIHP and/or its subcontractors have in place and follow, the following documents and processes:

1. Have in place and follow written policies and procedures for the processing of requests for initial and continuing authorizations of services. (see also 2.8 and 2.9)
2. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate.
3. That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. (see also 9.1.3)

Notice of Adverse Action: The CDRSN/PIHP notifies the requesting provider, and gives the enrollee written notice of any decision by the CDRSN/PIHP to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice meets the requirements of 438.404, except that the notice to the provider need not be in writing. If the CDRSN/PIHP denies services to an enrollee who meets medical necessity and Access Standards, the CDRSN/PIHP issues the NOA. If the CDRSN/PIHP determines through screening the enrollee that they do not meet medical necessity and/or the Access Standards, the CDRSN/PIHP notifies the enrollee. If the enrollee signals he/she wants to take issue with the decision, the CDRSN/PIHP offers the enrollee a second opinion for the screening function. CDRSN/PIHPs will offer a full clinical assessment to any and all enrollees who seek services. If the enrollee disagrees with the results of the assessment, the enrollee can request a second opinion, a second assessment from an independent clinician. If the enrollee is still not satisfied after a second opinion confirms the decision for no service, the enrollee is basically appealing this decision, and is given the NOA outlining their rights to appeal and due process.

BBA states: Two circumstances require the CDRSN/PIHP to issue the NOA:

1. The CDRSN/PIHP changes its benefit plan, Levels of Care.
2. The enrollee is determined not to meet medical necessity and/or Access to Care Standards.

On the provider level, changes to treatment plans in the course of treatment do not require NOAs. The standard of practice would call for

thorough involvement of the enrollee/consumer and family, if applicable, in treatment planning and course alterations.

The CDRSN/PIHP and its sub-contractor uses the State issued Notice of Adverse Action form attached to this policy. (see attached)

Timeframes for Decisions: The CDRSN/PIHP provides for the following decisions and notices:

1. Standard authorization decisions: For standard authorization decisions that do not deny or limit services, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—
  - a. The enrollee, or the provider, requests extension; or
  - b. The CDRSN/PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
  
2. Expedited authorization decisions: The CDRSN/PIHP follows these guidelines:
  - a. For cases in which a provider indicates, or the CDRSN/PIHP determines, that following the standard timeframe could seriously jeopardize the enrollees' life or health or ability attain, maintain, or regain maximum functions, the CDRSN/PIHP makes an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.
  - b. The CDRSN/PIHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the CDRSN/PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

Compensation for utilization management activities: The CDRSN/PIHP provides that, consistent with 438.6(h), and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

POLICY: INPATIENT CARE

*NOTE:*

*Authorization processes must exist for inpatient level of care. The following policy and procedures can be used to satisfy the*

*conditions above. The CDRSN/PIHP must have policies and procedures that address coverage, and actions taken to deny services to enrollees.*

The CDRSN/PIHP has an authorization processes and maintains up to date internal policies and procedures governing how the CDRSN/PIHP performs inpatient authorizations. The inpatient authorization process follows the requirements of the State MHD Exhibit E of the RSN Contract 2003-2005, otherwise know as "Memorandum #: 01-03 MAA", or the "numbered memorandum." The policies and procedures governing how these functions are performed cover initial authorization into service, concurrent review, and authorization extensions.

**PROCEDURE:** The BBA protocol addresses the Medical Director functions in various places. At a minimum, the protocol requires that a clinically appropriate person who has the necessary clinical expertise to make the decisions needed on a case. The behavioral healthcare community standard of practice would call for physician level decision making for inpatient level of care. The CDRSN/PIHP contracts with a licensed psychiatrist to review inpatient denials and provide consultation to the CDRSN/PIHP Clinical Director.

In the instance where a request for payment for any portion of an inpatient psychiatric stay has been denied by the CDRSN/PIHP, and the inpatient facility appeals that decision, the CDRSN/PIHP, within 14 days of the receipt of the appeal:

- a. Secures copies medical file information related to the course of inpatient care and document need for care.
- b. Submits copies of medical file to the contracted Psychiatric consultant for review and opinion as to whether clinical circumstances and services rendered were medically necessary.
- c. Consistent with the opinion of the Psychiatric consultant; the CDRSN/PIHP either authorizes payment for services or continues to deny payment for services.

When the inpatient facility, after reasonable effort to resolve the dispute, is not satisfied with the appeal decision, they may continue their appeal to Mental Health Division for further review.

- BBA regulations require clinical decisions to be made by appropriate professional level personnel whether it is concurrent or retrospective to ensure that any decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease."

- The CDRSN/PIHP Clinical Director shall be a board certified Psychiatrist, Psychologist, licensed Social Worker or Counselor, or a Masters level Mental Health Professional with at least five years experience in order to oversee Coverage and Authorization decisions, Utilization Management, grievances over clinical decisions, etc.
- In the event the CDRSN/PIHP does not employ a board certified Psychiatrist the CDRSN/PIHP shall ensure access, through contract or working agreement, to such a Psychiatrist for the purpose of consultation or review of inpatient denials.

The CDRSN/PIHP Clinical Director shall ensure completion of the following:

1. Review the CDRSN/PIHP's written service authorization policies and procedures. Determine the extent to which these policies and procedures:

- Specify information required for making authorization decisions and the criteria to be used in making the decisions.
- Promote consistent application of review criteria for authorization decisions.
- Specify time frames for responding to standard requests for service authorization that are within the applicable limits set by the State Medicaid agency.
- Assure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Provide for consultation with the requesting provider when appropriate.
- Provide for expedited response to requests for authorization of urgently needed services that adhere to the following time frames:
  - For cases in which a provider indicates, or the CDRSN/PIHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability attain, maintain, or regain maximum function, the CDRSN/PIHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.
  - The CDRSN/PIHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO or CDRSN/PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- Provide for notification of the requesting provider and the enrollee of any decision by the CDRSN/PIHP to deny a service authorization request, or to authorize a service in an amount, duration or scope

that is less than requested. Enrollee notification (but not provider notification) must be in writing. NOTE: State MHD draft Notice of Action letter now under review.

2. Review information sources identified by the CDRSN/PIHP such as service authorization tracking logs and other authorization record-keeping documents to determine: 1) the extent to which the CDRSN/PIHP complies with the State's time frames for standard and the above time frames for expedited authorization of service requests; and 2) the number and reasons for delayed expedited authorization of service requests.
3. Review a sample of service authorization requests that were denied. Determine the extent to which:
  - Decisions to deny a service were made by health care professional with appropriate clinical expertise in treating the enrollee's condition or disease.
  - Requesting providers were notified of any decision to deny, limit, or discontinue authorization of services, and
  - Enrollees were notified, in writing, of any decision to deny, limit, or discontinue authorization of services.
4. Review the CDRSN/PIHP's contracts or agreements with employees who perform utilization management activities. Determine the extent to which compensation to these individuals or entities does not appear to be structured in such a way as to provide incentives to deny, limit, or discontinue medically necessary services to any enrollee.
5. Review the CDRSN/PIHP's contracts or other agreements with utilization review organizations (or other reviewers who are not employees of the CDRSN/PIHP who perform utilization management activities) to determine that the contracts or agreements do not include any financial incentive for denial, limitation or discontinuation of authorization for medically necessary services.
6. Review the CDRSN/PIHP's written policies and procedures pertaining to utilization management relative to emergency and post-stabilization services. Determine the extent to which the written policies and procedures ensure that:
  - The CDRSN/PIHP covers and pays for emergency services regardless of whether the entity that furnishes the services has a contract with the CDRSN/PIHP... and regardless of whether or not the claim contains the primary care provider's authorization number.
  - The CDRSN/PIHP pays for treatment obtained under either of the following circumstances:

(A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1)(2) and (3) of the definition of “emergency medical condition” in paragraph (a) of this chapter.

(B) A representative of the CDRSN/PIHP... instructs the enrollee to seek emergency services.

- The CDRSN/PIHP does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and
- An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the CDRSN/PIHP.

7. Review grievance files or aggregate data related to payment/non-payment for services. Determine the extent to which there are records related to denial of payment for emergency or post-stabilization services.

SEE ALSO: Glossary of Terms and Acronyms

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# NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES

**To:** [Name of Medicaid Enrollee]/ Representative (if relevant) **Date:**  
Address  
Address

**From:** [Name of PIHP]  
[Address]  
Address

PIHP CONTACT PERSON CONCERNING THIS NOTICE: [Name and telephone number]

**This is to let you know about an action we are planning to take concerning your Medicaid-funded mental health services that you requested or are currently receiving.**

**We have decided that your** (Describe services) \_\_\_\_\_ **will be:**

- o **DENIED**  
EFFECTIVE DATE \_\_\_\_\_
- o **REDUCED TO** \_\_\_\_\_ **FROM** \_\_\_\_\_  
EFFECTIVE DATE \_\_\_\_\_
- o **SUSPENDED** EFFECTIVE DATE \_\_\_\_\_
- o **TERMINATED** EFFECTIVE DATE \_\_\_\_\_

**The reason for our decision is:**

- You are no longer a resident in this PIHP.
- You no longer meet Access to Care Standards.
- Other: \_\_\_\_\_

**Our decision is based on this law** \_\_\_\_\_

**WHAT IF I DON'T AGREE WITH THIS DECISION?** You have the right to appeal. **If you choose this right, you have twenty (20) calendar days from the date you receive this notice to request or file an appeal.<sup>1</sup> Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact:**

- \_\_\_\_\_ by calling 1-800-\_\_\_\_\_ or send your appeal to: \_\_\_\_\_

If you make your request verbally, you will be asked to put it in writing within seven (7) days. If your request is not put in writing, we will consider the request incomplete and not take further action. You may refile your appeal within twenty days from the original receipt of the notice.

**CAN I GET HELP WITH FILING AN APPEAL?** To get help with the appeal process you may contact the [PIHP name] Ombuds Service at 1-800\_\_\_\_\_. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process.

You may also include other persons of your choice to assist you during the appeal process. If you want someone else to assist you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711.

**WHAT HAPPENS AFTER I FILE AN APPEAL?** The PIHP reviews your appeal and provides a written decision within 45 days unless you have requested an extension. For additional information, please see the attachment, "Important Information About Your Appeal Rights".

<sup>1</sup>If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action. (42 CFR 438.210(a)(1))

## There Are Two Kinds of Appeals You Can File

**Standard (45 days)** You or your mental health care provider can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

**Fast (3 working days)** You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your health could be seriously harmed by waiting too long for a decision. We must decide on a fast appeal no later than 3 working days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for a fast appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for a fast appeal without support from your mental health care provider, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 45 days.

## What Do I Include With My Appeal?

You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information or present this information in person to: [PIHP name and address]

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## Definitions:

**Denial:** The decision by a PIHP not to authorize covered Medicaid mental health services that meet the Mental Health Division Access to Care Standards or the Medical Assistance Administration memorandum #01-03 MAA, Psychiatric Hospitalization. The decision by a Community Mental Health Agency (CMHA) not to provide a covered service is not a denial.

**Suspension:** The decision by a PIHP to temporarily stop an enrollee's previously authorized covered Medicaid mental health services. The decision by a CMHA to temporarily stop a covered service is not a suspension.

**Reduction:** The decision by a PIHP to decrease an enrollee's previously authorized covered Medicaid mental health services. The decision by a CMHA to decrease a covered service is not a reduction.

**Termination:** The decision by a PIHP to stop an enrollee's previously authorized covered Medicaid mental health services. The decision by a CMHA to stop a covered service is not a termination.

## How Do I File An Appeal?

**For a Standard Appeal:** You, your mental health provider, authorized representative, or an Ombudsman should mail or deliver your written appeal to the address below.

**For a Fast Appeal:** You, your mental health provider, authorized representative, or an Ombudsman should contact us by telephone or fax at the numbers listed below.

**Can I Continue to Receive Services?** If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed timely;
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services;
- Your covered Medicaid mental health services were ordered by the CMHA;
- The current period covered by the authorization has not expired; and
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

**What Happens Next?** After the PIHP makes a decision about your appeal and you do not agree with the PIHP decision, you may access a fair hearing through the WA State Department of Social and Health Services Office of Administrative Hearings (1-800-583-8271). You must request a fair hearing within 20 days after you receive the PIHP decision. You may also access a fair hearing if:

- The PIHP did not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

## Contact Information:

If you need information or help, call us at:

[PIHP name, address, 1-800 and fax numbers]

Hearing or Speech Impaired, please contact us:  
Telecommunication Relay Service at  
1-800-833-6384 or dial 711.

## Other Resources to Help You:

PIHP Ombuds Service  
[1-800- and fax numbers]

WA State Department of Social and Health Services Office of Administrative Hearings  
P. O. Box 42488  
Olympia, WA 98504-2488.  
1-800-583-8271