Types of UM Reviews

- **Retrospective Review**
  - A review conducted after the service has occurred to determine if the services were medically necessary.
  - This may occur when a membership retrospectively enrolled and there are extenuating circumstances such as the facility was unable to identify the member's coverage.
  - The provider or facility may submit a retrospective request prior to claims submission for a medical necessity review.

Medical Necessity

Washington State law defines medical necessity as:

- A requested service that is intended to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that
  - endanger life
  - cause suffering or pain
  - result in an illness or infirmity or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction

- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.

Utilization Management

NCQA Definition of Utilization Management:

Evaluating and determining coverage for and appropriateness of medical and behavioral health care services, as well as providing needed assistance to providers and patients, in cooperation with other parties, to ensure appropriate use of resources.

Utilization Management Regulations

MCOs must adhere to the following:

- IMC/WrapAround Contracts from HCA
- WACs and RCWs
- HCA Provider/Billing Guides
- HCA Health Technology Assessment Committee
- NCQA Standards

Prior Authorization Overview

How do I Know if I Need to Obtain a Prior Authorization?

- The MCO Authorization Grid details which Behavioral Health services require authorization and provides detail as to **what length of time** is initially authorized by EACH MCO.

- **What does Notification Only mean?**

  Emergent, unplanned admissions to acute inpatient BH facilities (such as E&T or acute inpatient detoxification) do not require prior authorization but do require notification of the admission by means of electronic file, fax or phone call within 24 hours of that admission. Clinical information shall be provided for medical necessity determination, known as concurrent review, following this notification.

  Notification Only can be required for lower level services as well.

MCO Combined Prior Auth Grid

Behavioral Health Provider Services Reference Guide

	Prior Authorization Required? *Length of Initial and Continued Stay Authorization *Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent as*				
Service Type and Description	**Amerigroup**	**CHPW**	**Coordinated Care**	**Molina**	**United**
Acute Inpatient Care – Mental Health and SUD • Acute Psychiatric Inpatient; Evaluation and Treatment • Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital • Inpatient Acute Withdrawal (Detoxification) ASAM 4.0 * Members admitted on an ITA are reviewed for change in legal status, confirmation of active treatment and transition of care needs. **If ITA, please attach court documents.**	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Initial: 3-5 days* *Initial and concurrent for ITAs is 14 days.*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Initial: 3-5 days*	**No.** Emergent admissions require notification only within 1 business day followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** ** Initial and concurrent: 3-5 days*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Authorization length segments:** ** **Voluntary admissions** - Initial and continued stay: 3-5 days (or Medical Director discretion)* ** **ITA admissions** – Initial for 72 hours, then dependent on further commitment will authorize 7 day increments. Upon confirmation of 90 day commitment, will authorize 14 day increments (or at Medical Director discretion).*	**No.** Emergent Acute admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Whole Person Care/Health Home Care coordinator.** **Initial: 3-5 days*

How do Prior Authorization and Concurrent Review Work?

Authorization requests can be submitted by fax, via the organization's web portal, and/or phone based off the individual MCOs processes.

Within the requested time frame, the next steps are:

- **Primary review:**
  - Licensed BH clinician reviews the clinical documentation provided against medical necessity criteria and if criteria is met, will approve and notify the provider of the authorization number and number of days or visits approved. This will include a "next review date" if a continuation of the service is expected.
- **Secondary review:**
  - All requests that do not meet criteria at the primary level will be escalated for review to the appropriate type of health care provider: Psychiatrist, Addictions Medicine specialist, Clinical Psychologist, Pharmacist, etc.

What Happens if Criteria is Not Met?

When a determination is made that a level of care not met or further care is not required a Partial or Full Denial may be issued. A denial will be communicated to the provider within 24 hours of the determination.

The MCO will:

- Work closely with providers to identify a transition plan.
- Assist provider and members in finding services that meet the member's needs.

If there is a disagreement about the adverse determination, there are options:

- Peer to Peer Review – initiated by provider
- Appeals - Member or Member Representative may request an appeal for a denied service or authorization within 60 calendar days of the denial.

Prior Authorization Requests When Bed Date is TBD (Bed date estimated)

Best practice: Provider/Referent should request admission to RTF as close to bed date availability as possible.

Clinical being provided with request should be current and comprehensive. This clinical information can be submitted by the referral source or by the provider of the services.

The process for requesting authorization when bed date is not specified but expected to occur within a "window" of time varies between MCOs/BH-ASO. Best practice is to inquire about individual MCO/BH-ASO practices regarding this process.

Prior Authorizations when Correctional Facilities Release to SUD Residential Facilities "Honor authorizations"/Notifications

When a client who has Apple Health (Medicaid) coverage is incarcerated, they will continue to retain their status as a Medicaid client. However, their Apple Health benefits are suspended while in a correctional facility.

Post-incarceration, benefits cannot be confirmed until the person is released and the ProviderOne suspended status has ended. It can take HCA up to 1 business day to update client's status in ProviderOne.

Steps:

1. **Identify the Managed Care Organization** (MCO) the client was enrolled with prior to incarceration and confirm the plan is still available in your region.
2. If the MCO **approves** the PA for services, the plan will provide a notification of contingent approval to the provider coordinating the admission. This approval is based upon the individual's anticipated reinstatement of benefits. This is referred to as an **"Honor Authorization".**

Transition Authorizations from BHO to MCOs

- These are authorizations for “bedded” BH services already given by the BHO to members in service who become MCO members effective 1/1/2020.
  - BHO provides authorization data to HCA, who will pass to MCOs.
  - MCO confirms member is in active treatment in a level of acuity that requires authorization in order to be paid and which is expected to cross over 1/1/20 with the identified provider of those services. If not in active treatment, MCO will work with provider to determine if there is a scheduled bed date. If no scheduled bed date, provider should follow routine process for authorization request if and when needed.
  - MCO enters transitional authorization of those services to “X” date with instructions to provider on how to complete continued stay review and MCO assumes responsibility for ongoing medical necessity reviews/authorization.

Amerigroup Prior Authorization Process

- Confirm if services require prior authorization on our website, https://providers.amerigroup.com/Pages/PLUTO.aspx
- Requests can be submitted via telephone, fax or online
- Providers are notified of authorization decisions via phone or fax
- Providers and members receive faxed and written notice of denial decisions

Issues with obtaining a prior authorization can be directed:

Kathleen Boyle, Director of Practice Integration:

Kathleen.Boyle2@Amerigroup.com
206-482-5523

Amerigroup RealSolutions in healthcare

How to Request a Prior Authorization

Portal: https://www.availity.com

Prior authorization forms are online: :
Amerigroup.com/Washington/Providers/Forms

Initial Inpatient Prior Authorization
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Concurrent Review
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

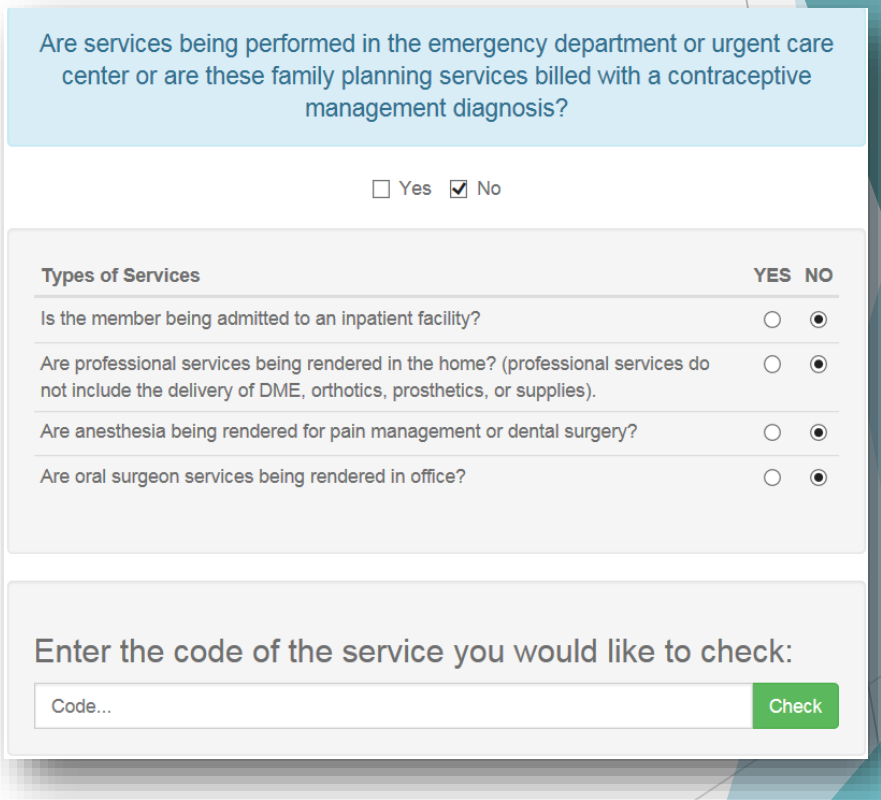
Outpatient Prior Authorization
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Address:
705 5th Avenue S., Ste 300
Seattle, WA 98104

Amerigroup
An Anthem Company

Coordinated Care Prior Authorization

- Use the Pre-Auth Check Tool on our website to determine if PA is required
  - Not a guarantee of payment, please verify benefit coverage/limitations in the HCA guides
  - Emergency stabilization services are exempt
- PA Requests and General Information:
  - Fax form which can be found on our website
- Covered services by OON providers:
  - When continuity of care applies, members are able to access care up to 90 days with previous provider
  - PA is required for many covered services, excluding urgent/emergent



coordinated care

Coordinated Care Prior Authorization Contact Numbers

- Authorization can be requested using a faxed form, or provider web portal
  - Utilization Department Main Contact number:
    - (844)208-8885
  - Fax forms:
    - Behavioral Health Fax Number (833)286-1086
  - Web Portal
- CCW Behavioral Health Leadership
  - Amanda McLendon, Clinical Manager (509)637-5671

coordinated care

Molina Prior Authorization Requests

- BH Prior Authorization request form is located at: www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx
  - CLICK – forms in the menu, then Frequently Used Forms from the dropdown menu

- Molina Behavioral Health Prior Authorization Guide:
  - Located within the Provider Web Portal: https://provider.molinahealthcare.com/provider/login

- Molina Prior Authorization by CPT Code Guide
  - Provides prior authorization requirements based on specific procedure code, place of service, etc. Available via the Provider Web Portal: https://provider.molinahealthcare.com/provider/login

MOLINA HEALTHCARE
Your Extended Family.

Molina BH Prior Authorization Contacts

To request an authorization or check the status of a request:

- Provider Web Portal

To fax in a request for services:

- Prior Authorization Fax: (800) 767-7188

To check the status of a request or get assistance with an authorization:

- Healthcare Services (Prior Authorization): (800) 869-7175

For any prior authorization escalated issues that cannot be resolved through the prior authorization line, contact BH UM management:

Denise Kohler, LICSW
Manager BH UM Team
800-869-7175 Ext. 140257

Laurie McCraney RN MBA
Director, Healthcare Services
Desk: 425-354-1572

MOLINA HEALTHCARE
Your Extended Family.

United Healthcare BH Prior Authorization Methods

Call

- United HealthCare Call Center: (877) 542-9231
- IP & Res reviews 24/7
- Non-Routine Outpatient: Call during business hours

Online
Preferred method of submission

- Available: https://www.uhcprovider.com/en/prior-auth-advance-notification.html
- Frequently used non-routine services where an authorization can be requested online include: Psychological Testing, Transcranial Magnetic Stimulation (TMS), GFS funded services and ABA/Autism
- For other non-routine services call the number on the back of the Member's ID card to request authorization.

Fax

- IMC Fax Form available and to: (844) 747-9828

UnitedHealthcare Community Plan

United Healthcare BH Prior Authorization Contacts

To request an authorization or check the status of a request:

- Provider Web Portal: Providerexpress.com
- Healthcare Services (Prior Authorization): (877) 542-9231

To fax in a request for services:

- Prior Authorization Fax: (844) 747-9828

For any prior authorization escalated issues that cannot be resolved through the prior authorization line, contact:

Region	Network Contact	Email	Phone
Thurston Mason/ Great Rivers	Renee (Randi) Johnson	Randi.Johnson@Optum.com	(425)201-7106

UnitedHealthcare Community Plan

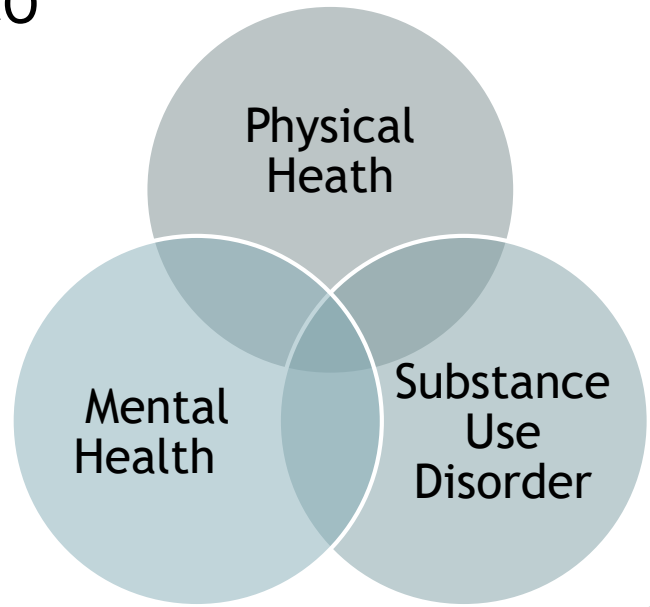
Case Management Overview

MCO Case Management

- Is NOT intended, in any way, to replace providers' current Case Management services;
- Strives to enhance or supplement current efforts and reduce duplication of work.
- Is a partner at the multidisciplinary team table;
- Is a resource for the members, providers, colleagues and MCO counterparts;
- Collaborates with other existing teams to effectively manage complex individuals or populations; and

Care Coordination with Integrated Managed Care (IMC)

- Community Based Care Coordination
  - Working with PCP and BH providers to coordinate and collaborate
  - Local providers know the patient best
  - Allied Service Coordination (Community Partners)
- Coordination of BH Services by MCO
  - SUD
  - State Facilities
  - Outpatient Wrap Around Care
  - Justice System
  - BH-ASO Crisis Services



Initial Health Screening

Newly enrolled members receive an Initial Health Screening within the first 60 days of enrollment

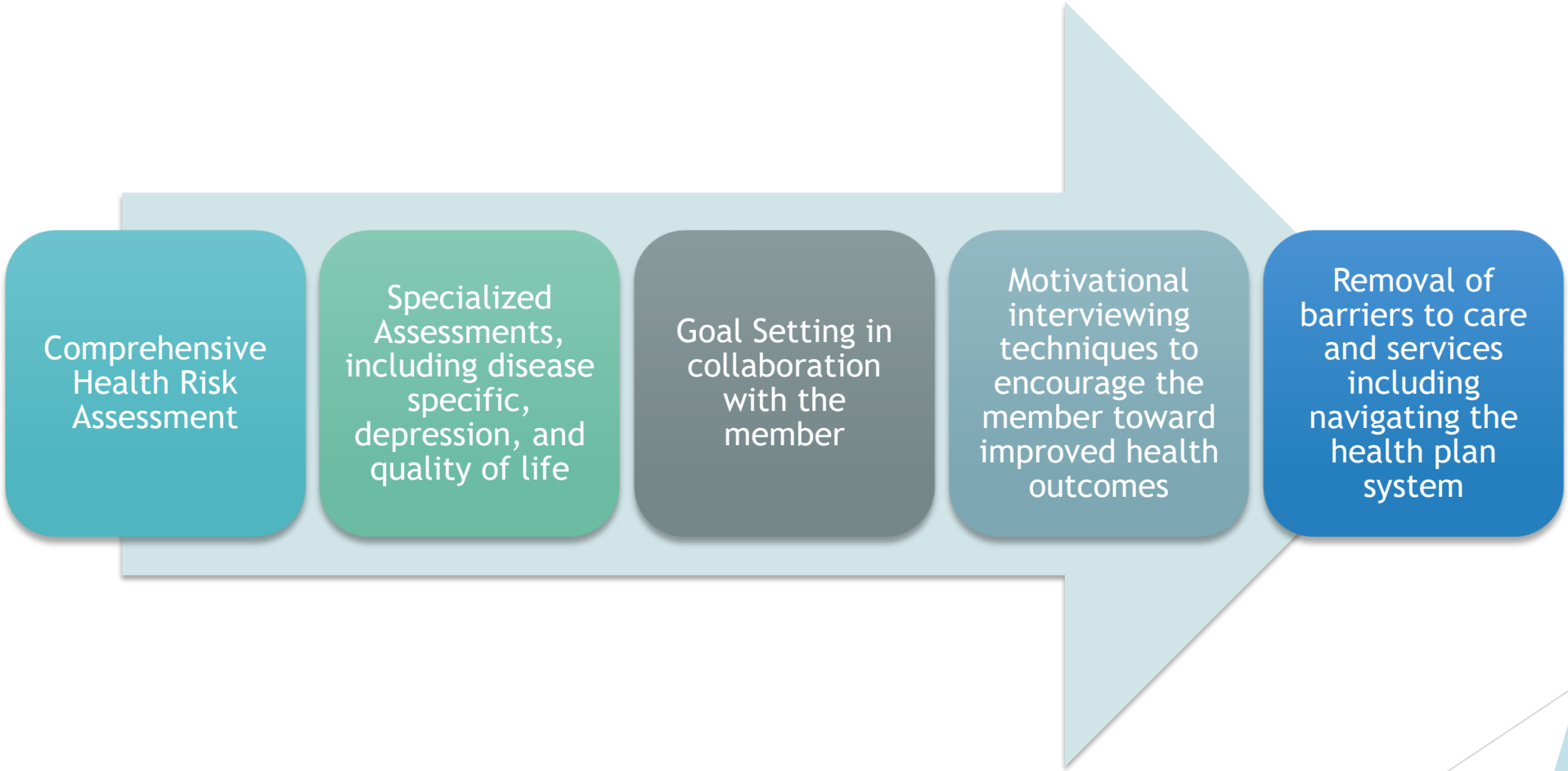
However, many members are difficult to contact

Based on screening results and other utilization data, members are referred to Care Management for further assessment

Examples for Case Management Referrals:

- High utilizer of care
- Members with complex and/or comorbid conditions
- Difficulty managing a chronic condition
- Psychosocial needs impacting management
- Assistance navigating health plan system
- Gaps in care

Case Management Process



Care Management Levels

MCOs offer three levels of Care Management Services:

1. Care Coordination Services (CCS)
   - Focus on short-term or intermittent needs, such as:
     - Access to care/services addressing social needs
     - Improving clinical outcomes
     - Increasing self-management skills
2. Medical Case Management
   - Three to six months engagement
     - Assist members in managing complex healthcare needs
     - Goal setting based on the individual's priorities
     - Integrated care planning

Care Management services are designed to support the overall Wellness of members with a focus on improving health outcomes.

Care Management Levels

3. Complex Case Management (CCM)
   - Focus on individuals with chronic or complex needs requiring ongoing care management. Services include:
     - Person-centered approach to care plan development
     - Utilization of evidence-based practices in screening and intervention
     - Addressing gaps in care
     - Coordination of care across the continuum
     - Designed to meet NCQA Complex Case Management standards

Children's Programs

- Each MCO has designated case managers to support and serve our children and youth population
- Manage transitions into and out of WISe (Wrap Around Intensive)
- Review the " interest" list of youth waiting to be served in WISe
- Support families by attending Family/System partner meetings
- Support families who are seeking or requesting a CLIP (Children's Long term inpatient Program) referral
- Presenting cases to the CLIP committee for review and finding ways to support families to keep them out of CLIP and in their community.
- Manage transitions between Admission and Discharge from a CLIP facility
- Participate in Community based work groups that serve kids, like FYSPRT, Youth Collaboratives and/ or WISe Collaboratives

WISe Notification Form

- Notification Form should be completed for the following reasons:
  - Enrollment of new WISe client
  - Adverse Benefit Determination (ABD)
    - WISe Provider determines the following:
      - Denial
      - Termination
      - Reduction of Services
      - Suspension

WISe
Wraparound with Intensive Services

Refer to WISe Manual for detailed descriptions of ABDs

WISe Tracker

- Monthly report due by 5th of month
  - Enrollment: Number of WISe members in the program during the month.
  - Service Intensity: Average number of services your WISe enrollees received during the month.
  - Interest List: Members who have been screened but are waiting to get into WISe.

MCOs will be outreaching to Providers to discuss expectations and procedures in greater detail.

Transitions of Care

- Transitional care services are provided to all members who are transitioning from one level/setting of care to another;
- Development/completion of a standardized discharge screening tool;
- Development of an individual plan to reduce the risk of readmission or treatment recidivism, to include:
  - Information that supports discharge care needs, medication management, action to ensure follow-up appointments are attended, and follow-up for self-management
  - When to seek medical or emergency care
  - Including formal and informal caregivers in this process, as the member allows
  - Written discharge plan
  - Follow-up plan

Transitions of Care

- Organized post-discharge services, such as home health or therapy or post-acute placement
- Telephonic follow-up to reinforce the discharge plan and problem solving,
  2-3 days post-discharge;
- A plan in the event a problem arises following discharge;
- A face to face visit to the member, while in the hospital, for those who are at high risk of readmission, to coordinate the transition;
- For members at high risk for readmission, a face to face visit, an in-person assessment for post-discharge support within seven (7) calendar days of hospital discharge.
- Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days and again within 30 days following discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge.

Program Integrity and Monitoring

Program Integrity and Monitoring • Member Grievance and Appeal • Advance Directives • Critical Incidents • Behavioral Health Ombudsman