SALISH BHO

INPATIENT POLICIES AND PROCEDURES

Policy Name: VOLUNTARY INPATIENT DENIALS **Policy Number:** 12.02

Reference: 42 CFR 438.210, State contract 2.2

Effective Date: 5/2005

Revision Date(s): 6/2016; 5/2018

Reviewed Date: 6/2016; 7/2017; 5/2018

Approved by: SBHO Executive Board

CROSS REFERENCES

- Policy: Corrective Action Plan
- Policy: Notice of Action Requirements
- Policy: State Inpatient Billing Instructions

PURPOSE

The Salish Behavioral Health Organization (SBHO) utilization management contractor, CommCare, is responsible for authorizing voluntary community inpatient psychiatric care. CommCare uses the SBHO Levels of Care to make decisions regarding voluntary inpatient requests for initial and continuing stay certifications. The SBHO requires CommCare utilize mechanisms to respond to appeals of denial determinations on an immediate basis.

CommCare's appeal policy and procedures adhere to URAC standards. The process offers Medicaid clients or client representatives and providers a systematic process to appeal a non-certification resulting from the absence of medical necessity. Any provider, client, or client representative may file such an appeal telephonically or in writing.

PROCEDURE

1. The SBHO contracts the utilization management authorization decisions for voluntary inpatient care admissions and continuing stay requests in evaluation and treatment centers, and community hospitals to CommCare.
2. The SBHO managed care contractor and network providers shall comply with procedures outlined in the current State Inpatient Instructions and all revisions to the instructions.

3. CommCare may choose to not authorize the request for voluntary inpatient admission and/or length of stay extensions, as outlined in the SBHO Level of Care Voluntary Inpatient criteria, if any of the following applies:
   a. The level of care is not medically necessary
   b. The need for inpatient care does not result from a mental disorder
   c. A clinically appropriate diversion alternative exists
   d. To avoid potential consequences of involuntary admission, including medication as prescribed by the staff psychiatrist, or to avoid a least restrictive alternative (LRA) petition upon discharge
   e. As a manipulation to avoid the unpleasant consequences of detention or incarceration
   f. As an admission for custodial or domiciliary care due to homelessness or lack of placement
   g. If there is evidence of a chronic mental health condition without evidence of acute exacerbation leading to danger to self, others, property or grave disability
4. The following is an overview of CommCare's procedure:
   a. Peer-to-Peer Conversation
      - If a care manager is not able to authorize voluntary inpatient services based on the medical necessity criteria, the case is referred to CommCare's Medical Director or a CommCare consulting psychiatrist and the attending clinician is offered an opportunity to speak to a Peer Reviewer.

   b. Expedited Appeal
      - If a requested authorization for a Covered Service is denied by the CommCare Medical Director, a request may be made by the attending clinician for an Expedited Appeal.

        An Expedited Appeal is a request to review a denial while the Client is still in an acute care psychiatric unit.

        The case is referred to a Physician Consultant who is board certified in the relevant clinical specialty (e.g., child and adolescent). Expedited appeals are reviewed by CommCare within one (1) working day.

        If the denial is upheld, a non-certification letter is sent to the provider and the client along with a Notice of Action to Medicaid individuals.

   c. Standard Appeal
      - The provider may choose to make a Standard Appeal even if an Expedited Appeal has already been completed. This allows the provider the opportunity to submit additional clinical documentation to support medical necessity. CommCare requests all relevant medical records for the Standard Appeal.
      - For an inpatient denial, the appeal is reviewed by a Physician Consultant who is board certified in the relevant clinical specialty, within fourteen (14) calendar days.

If the decision is made to uphold the denial, a non-certification letter is mailed to the network provider, hospital, SBHO office and the client.

d. For both Expedited and Standard appeals, if the Physician Consultant certifies the previously denied services, a reversal letter is sent to the provider and the client.

- Coordination for the voluntary inpatient care will be the responsibility of network agency and shall be provided as soon as possible.

e. Committee Review Appeal

- A Committee Review is CommCare's final level of appeal for medical necessity of Medicaid individuals. The case is presented to CommCare's Quality Improvement Committee for review.

  A letter is sent indicating the decision of the committee to the provider and client within thirty (30) calendar days of the receipt of the chart.

5. A copy of all Notice of Adverse Benefit Determination (NOABD) letters to Medicaid individuals must be copied and mailed to the SBHO office.
6. The community hospital may appeal the SBHO denial of payment decision to the State after all reasonable effort is made to resolve the dispute between the SBHO and the community hospital.

MONITORING

1. This policy is a contract and statute mandate. The SBHO will be monitor this policy through use of the:
   - Annual SBHO Provider and Subcontractor Administrative Review
   - Annual Provider Chart Reviews
   - SBHO Grievance Tracking Reports
   - Quarterly Provider Performance Reports
   - Quality Management Plan activities, such as review targeted issues for trends and recommendations
2. If a network provider or subcontractor performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval. Reference SBHO Corrective Action Plan Policy.