SALISH BEHAVIORAL HEALTH ORGANIZATION

UTILIZATION MANAGEMENT POLICIES AND PROCEDURES

Policy Number: 7.01

Policy Name: ENROLLMENT FOR OUTPATIENT SERVICES BASED ON MEDICAL NECESSITY

Reference: 42 CFR 438.207, -.210; 42 CFR 438.402, -.424
WAC 388-865-0242; WAC 388-865-0238;
WAC 182-538D-0665; State Contract; WISe Manual
Version 1.7

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Approved by: SBHO Executive Board

CROSS REFERENCES

- Letter: Notice of Adverse Benefit Determination Form Letter Template
- Letter: SBHO Notice of Determination
- Policy: Corrective Action Plan
- Policy: Notice of Adverse Benefit Determination Requirements

PURPOSE

To ensure the Salish Behavioral Health Organization (SBHO) and network providers share a standardized process for enrolling individuals in care based on the medical necessity established by the SBHO.

The SBHO has adopted a “medical necessity” definition that includes the Washington Administrative Code (WAC), the state contract definition for medical necessity, the statewide Access to Care standards, and ASAM criteria. This policy applies to outpatient enrollment determinations for Medicaid and non-Medicaid individuals.

- Non-Medicaid outpatient and residential services are authorized within available resources.

DEFINITIONS

Access to Care Standards (ACS) are defined as standards established by the State that SBHO must implement for the purposes of determining minimum eligibility for Medicaid enrollees and non-Medicaid individuals seeking behavioral health services.

Enrollee A Medicaid recipient who is enrolled in a Pre-Paid Inpatient Health Plan (PIHP).

Individual means a person who has applied for, is eligible for, or who has received publicly funded mental health services.

- For a child under the age of thirteen, the definition of individual includes the parents or legal guardians.
- For a child thirteen years or older who provides consent for their parents or legal guardians to be involved in the treatment planning, the definition of individual includes the parents or legal guardians.

Medical necessity (or medically necessary) is defined by WAC as a term to describe 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 or 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 definition “course of treatment” may include mere observation or, where appropriate, no treatment at all.

Request for Services means the point in time when services are sought or applied for through a telephone call, walk-in, or written request for services from an Enrollee or the Authorized Representative.

WISe (Wraparound with Intensive Services) is a range of Medicaid-funded service components that are individualized, intensive, coordinated, comprehensive, culturally relevant, and home and community based. WISe is for youth who are experiencing mental health symptoms that disrupt or interfere with their functioning with the family, school, or with peers.

PROCEDURE

1. Following an Intake Assessment. Enrollment decisions are made by agency staff (mental health professional for mental health services, or chemical dependency professional or Master Addictions Counselor for substance use disorder services), who have the appropriate clinical expertise to determine if the individual’s current condition/diagnosis meets SBHO adopted medical necessity criteria as defined above.
    - In consultation with a specialist, if required
    - Excluding WISe services

a. The enrollment decision must occur within 14 (fourteen) calendar days of the date of the Request for Service.

- The network provider is required to request an extension if medical necessity cannot be established and/or additional time is required beyond the 14 (fourteen) day limit.
- An extension request can only be approved for up to14 (fourteen) additional calendar days.

c. An expedited request for service is made in cases when following the standard time frame could seriously jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. An expedited decision must be made as expeditiously as the individual's condition requires but not to exceed 72 calendar hours from the request for service.

d. An individual must meet the Washington State Access to Care Standards and medical necessity criteria to be enrolled in services.

e. For non-Medicaid individuals, all of the above apply, in addition to within available resources and other admission criteria identified in the SBHO Levels of Care.

2. Service Denial Decisions. SBHO will review all denial requests.

Prior to a service denial decision based on clinical criteria, the SBHO will:

- Conduct a review, to include staff with clinical expertise with the individuals specific need, and review all of the SBHO required documentation and additionally requested information, requesting additional information, if needed.

3. Notice of Adverse Benefit Determination (NOABD) Requirements.

a. In the event requested Medicaid services are denied, SBHO mails a written Notice of Adverse Benefit Determination (NOABD) letter within 14 (fourteen) days of the Request for Services to the individual at the last known address. All WISe service level ineligibility determinations as defined by the CANS screen will initiate a NOABD letter within 14 (fourteen) days of the Request for Services.

b. The written NOABD letter must include all of the elements listed below:

- The adverse benefit determination the SBHO has taken or intends to take;
- The reasons for the adverse benefit determination, including citation of the rule(s) and criteria used for the basis of the decision;
- The right of the individual to be provided reasonable access to and copies of all documents, records, and other information relevant to the individual's adverse benefit determination upon request and free of charge;
- The individual's right to file an appeal of the adverse benefit determination with the BHO, including information on exhausting the BHO's one level of appeal and the individual's right to request an administrative hearing;

- The circumstances under which an expedited appeal process is available and how to request it; and
- The individual's right to receive behavioral health services while an appeal is pending, how to make the request, and that the individual may be held liable for the cost of services received while the appeal is pending if the appeal decision upholds the decision in the NOABD.
- In the event WISe services are denied based on the CANS algorithm, the NOABD letter will include information to request a “re-screen” for WISe level of services.

4. <u>Notice of Determination (NOD) Requirements</u>

   a. The Notice of Determination letter is a written notice that must be provided to individuals by the SBHO to inform them that non-Medicaid services, available per the SBHO’s policy and procedures, have not been authorized, and the reason for this determination. A Notice of Determination must contain the following:
      - The reason for denial or offering of alternative services;
      - A description of alternative services, if available; and
      - The right to request a Fair Hearing.

MONITORING

This policy is mandated by statute and contract.

1. The SBHO monitors this policy through the use of:
   - Annual Provider Chart Reviews
   - SBHO Grievance Tracking Reports
   - Biennial Provider Quality Review Team review
   - Utilization Management Committee activities
   - Quality Management Plan activities, such as review of targeted measures for trends and recommendations

2. If a provider performs below expected standards during any of the reviews listed above, a Corrective Action Plan will be required for SBHO approval.