BEHAVIORAL HEALTH SYSTEMS

CLINICAL POLICIES

SUBJECT: MEDICAL NECESSITY: REVIEW STANDARDS (URGENT CARE)

BOARD APPROVAL DATE: 8/19/92 **REVISED:** 10/27/93 10/22/97 09/13/99 06/28/00 06/27/01 07/01/02 07/27/04 11/18/04 08/01/06 04/01/07 01/01/11 04/01/11 01/01/12 07/01/14 07/01/15 07/07/16 05/01/19 11/01/19

PURPOSE:

1. To establish guidelines for urgent care BHS medical necessity review;
2. To describe the medical necessity review process.

POLICY:

CASE MANAGEMENT/MEDICAL NECESSITY REVIEW STANDARDS

I. Scope of the BHS Medical Necessity Review Standards

A. These standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities as well as for other urgent care services, i.e., partial hospitalization and residential care (if covered by the benefit plan).

B. “Inpatient admissions to hospitals” as used in these standards, includes admissions to all acute psychiatric and substance abuse inpatient, partial hospitalization, and residential services at a licensed hospital facility, as well as other licensed inpatient facilities such as residential treatment centers and freestanding rehabilitation facilities.

C. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary or that it is covered under the Benefit Plan. In determining questions of reasonableness and necessity, due consideration will be given to the customary practices of physicians in the community where the service is provided.

D. Many, but not all, of BHS’ clients’ benefit plans are subject to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Except as otherwise required/allowed by the specific plan, Covered Members must obtain BHS’ precertification for inpatient

hospitalization, partial hospitalization, and residential care (if covered by the benefit plan). The absence of a precertification requirement under a plan does not affect BHS' right to determine the medical necessity of any service before, during, or after care is rendered.

II. Responsibility for Obtaining Certification

In the absence of any contractual agreement to the contrary, the Covered Member is responsible for notifying BHS in a timely manner and obtaining certification for health care services. BHS shall allow any licensed hospital, physician or responsible patient representative, including a family member, to assist in fulfilling that responsibility.[1]

III. Information Upon Which Medical Necessity Review is Conducted

A. When conducting routine prospective and concurrent utilization review, BHS shall collect only the information necessary to certify the admission, procedure or treatment and length of stay, or frequency or duration of services, and make its certification determinations based only on the information obtained by BHS at the time of the review determination.

1. BHS shall not routinely request copies of medical records on all patients reviewed. Should BHS be unable to obtain regular complete updates during continuation of stay reviews, or to determine demonstrated medical necessity through such updates, BHS shall request copies of medical records to determine demonstrated medical necessity. BHS shall require only the section(s) of the medical record necessary to certify medical necessity or appropriateness of the admission or extension of stay, or frequency or duration of services.

2. BHS may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, evaluation of compliance with the terms of the health benefit plan or BHS provisions.

B. Except as otherwise provided in these standards, BHS will ask for the following information initially.

Patient Information

Name
Address
Date of Birth
Sex
SS No. or Patient ID No.

Covered Member Information

Name
Address
SS No. or Employee ID No.
Relation to Patient
Employer
Health Benefit Plan
Other Coverages Available (Workers Comp., Auto, Champus, Medicare, Other)

Attending Physician/Practitioner Information

Name
Address
Phone Numbers
Degree
Specialty/Certification Status

Diagnosis/Treatment Information

Primary Diagnosis (with associated ICD or DSM Coding, if available)
Secondary Diagnosis (with associated ICD or DSM Coding, if available)
Tertiary Diagnoses (with associated ICD or DSM Coding, if available)
Proposed Procedures(s) or Treatment(s) (with ICD9 or associated CPT Codes, if available)
Proposed Admission or Service Date(s)
Proposed Procedure Date
Proposed Length of Stay

Clinical Information (sufficient for support of appropriateness and level of service proposed)

Facility Information

Type (such as inpatient, outpatient, specialty unit, SNF, rehab, office/clinic)
Status (licensure/certification status and DRG exempt status, as needed)
Name
Address
Phone Number

Concurrent (Continued Stay) Review Information

Clinical Contact Person
Additional Days/Services Proposed
Diagnoses (same/changed)
Clinical Information (sufficient for support of appropriateness and level of service proposed)

For Admissions to Facilities other than Acute Medical/Surgical Hospitals, Added Information on:

History of Present Illness
Patient Treatment Plan and Goals
Prognosis

For Special Situations

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second Opinion Information may also be required, when applicable, sufficient to support benefit plan requirements.

C. Information in addition to that described in this section may be requested by BHS or voluntarily submitted by the provider, when there is significant lack of agreement between

BHS and the health care provider regarding the appropriateness of certification during the review or appeal process. "Significant lack of agreement" means that BHS:

1. has tentatively determined, through its professional staff, that a service cannot be certified;

2. has referred the case to an independent physician for review; and

3. has talked to or attempted to talk to the attending physician for further information.

D. BHS will share all clinical and demographic information on individual patients among its various divisions that have a need to know (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from the Covered Member or providers.

IV. Procedures for Review Determination[2]

A. Pre-Authorization Review[3]

BHS shall make initial certification determinations and provide notification thereof within 72 hours of receipt of the request for a review determination on a proposed admission or service requiring a review[4]. Notification shall be given as described in paragraph D., below.

Collection of the information necessary to complete the review may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review. Collection of such information is subject to the time limitations described in paragraph C., below.

B. Concurrent Review

BHS will, as a rule, review ongoing urgent care stays, every three days. The frequency of the review for extension of the initial determination may vary, however, based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity. BHS shall make its determination and provide notification thereof within 24 hours of receiving this request, provided the request was received at least 24 hours prior to the expiration of the currently certified period.[5] Requests received after that time will be handled as a pre-authorization review. Notification shall be given as described in paragraph D., below.

Any reduction or termination of previously approved treatment is considered an adverse benefit determination. Any such determination shall be issued with sufficient time to allow the patient to request a review and receive a review decision before the reduction or termination occurs.

C. Request for Information

If the patient, provider or facility fails to provide the information necessary to review the proposed admission or service, BHS shall, within 24 hours of receiving the request for pre-

authorization, notify the attending physician, facility and enrollee or patient of the information that is needed. Notice may be oral or written. The parties shall have 48 hours to provide such information. BHS shall then have an additional 48 hours from the receipt of the information to make its benefit determination.

However, if a response is not received within the 48-hour period or if the patient, provider or facility refuses to release information to BHS, BHS will immediately send written notification of its adverse benefit determination to the attending physician, facility, enrollee or patient.[6]

D. Notice of Benefit Determination[7]

When a determination is made to certify a hospital admission, or other service requiring review determination, the attending physician, facility, and the enrollee or patient shall be notified during their normal business hours by telephone or in writing.[8] Any party notified by telephone may request written confirmation as well. Written confirmation of certification for continued hospitalization, or other services requiring review, shall include the number of extended days, the next anticipated review date, the new total number of days or services approved, and the date of admission or onset of services.

When a determination is made not to certify such admission or other service, the attending physician and facility shall be notified during their normal business hours by telephone and a written non-certification letter will be sent to the hospital, attending physician, and the enrollee or patient.

Notice of an adverse benefit determination shall include[9]:

1. The specific reason(s) for the denial;
2. Reference to the plan provision(s) on which the denial is based;
3. A description of, and reason for, any additional information necessary;
4. A description of the appeal procedures, including applicable time limits and a statement of the member's right to bring a civil action following appeal; and
5. A statement that upon request, any rule, guideline, or protocol, or clinical rationale, in the case of a medical necessity denial, used in making the non-certification decision will be provided in writing, and instructions for requesting a clinical rationale. BHS may, in the interest of the patient's well-being, disclose the clinical rationale to the patient's provider, and refer the patient to the provider for disclosure and explanation.

Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

Upon request, BHS shall identify any independent physician reviewer(s) involved in the review process.

V. Appeals of Determination Not to Certify (Refer to Appeals Process Policy)

When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, the patient, enrollee, provider or other representative shall have an opportunity to appeal that determination in accordance with the BHS appeals process.[10]

VI. Confidentiality

A. Patient-specific information (that information allowing identification of an individual patient) obtained during the process of utilization review will be:

1. kept confidential in accordance with applicable federal and state laws;

2. used solely for the purposes of utilization review, quality assurance, disease management, discharge planning, case management, and claims payment;

3. shared with only those entities who have authority to receive such information; and

4. shared with only those BHS employees who need access to conduct utilization review and related processes.

B. Summary data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

VII. Staff and Program Qualifications

A. Nurses, physicians and other licensed health professionals conducting reviews of clinical services, and other clinical reviewers conducting specialized reviews in their area of specialty shall be currently licensed or certified by an approved state licensing agency in the United States.

B. BHS shall not issue a non-certification based on initial screening. A physician shall review all cases in which BHS has concluded that a determination not to certify for clinical reasons is appropriate.[11] The physician will be reasonably available to discuss the determination with the attending physician by telephone.

C. BHS shall utilize:

1. Written clinical criteria, as needed, for the purpose of determining the appropriateness of the certification; such criteria will be periodically evaluated and updated.

2. Physician reviewers, including, as needed and available, specialists who are certified by the Boards within the American Board of Medical Specialists or the American Board of Osteopathy from the major areas of clinical services. The physician reviewer will be board-certified in the same specialty or subspecialty of the attending physician when possible.

3. A formal program for orientation and training of UR staff.

4. Written documentation of an active Quality Review Program.

VIII. Accessibility and On-Site Review Procedures

A. BHS shall provide access to its review staff by a national toll free or collect call phone line, at a minimum, from 8:00 a.m. to 5:00 p.m. of each normal business day in the local time zone in which BHS routinely conducts review.[12] After hours access is also provided through an answering service. BHS has an on-call care coordinator available after hours for prompt handling of emergency calls. All other calls will be returned the next business day.

B. BHS shall conduct its telephone and on-site information gathering reviews and hospital communications during hospitals' and physicians' reasonable and normal business hours, unless otherwise mutually agreed.

C. BHS staff shall identify themselves by name and title, and by the name and, if applicable, the utilization review certification number, of their organization. On-site reviews will, whenever possible, be scheduled at least one business day in advance with the appropriate hospital contact. BHS on-site review staff will carry a picture ID with full name, register with the appropriate contact position prior to requesting any clinical information or assistance from hospital-staff, and wear appropriate hospital supplied identification tags while on the premises, if so required.

D. BHS shall agree, if so requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures shall be followed by on-site review staff so as not to disrupt hospital operations or patient care. Such procedures, however, should not limit the ability of BHS to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

E. BHS will verbally inform, upon request, the enrollee or patient, designated hospital personnel and/or the attending physician of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. BHS will also verbally inform, upon request, hospitals, physicians and other health care professionals of the operational procedures in order to facilitate the review process.

[1] With respect to **Alabama** patients, BHS shall allow a minimum of 24 hours after an emergency admission, service or procedure for the enrollee or the enrollee's representative to contact BHS.

[2] With respect to **members under non-grandfathered plans**, upon request, BHS shall allow a member to review the claim file and to present evidence and testimony as part of the claims process.

[3] With respect to **Tennessee** patients, BHS shall notify contracted providers in writing of any new or amended preauthorization requirement or restriction no less than sixty (60) days prior to implementation thereof.

[4] With respect to **Kentucky** patients, all preadmission reviews of hospital admissions shall be considered urgent care. Urgent care means health care or treatment with respect to which the application of the time periods for making non-urgent determinations:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

With respect to **Alabama, Indiana, or Tennessee** patients, BHS shall provide written notification of its certification decision to the hospital, attending physician and the enrollee or patient within two business days of receipt of all necessary information, if earlier.

With respect to **Mississippi** patients, BHS shall provide to the hospital, attending physician and the enrollee or patient written notification of a non-certification decision within one business day, and written notification of a certification decision within two business days, of receipt of all necessary information, if earlier.

[5] With respect to **Kentucky** patients, a certification decision shall be given within 24 hours of receipt of a request to certify an extension of a hospital stay and prior to the time when a previous authorization for hospital care will expire.

With respect to **Mississippi** patients, a certification decision shall be given within one business day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.

[6] With respect to **Kentucky** patients, this footnote applies only until BHS issues a utilization review determination applicable to the request for review, and only when the request for review concerns covered health benefits and it shall not supersede any limitations or exclusions in the patient's health benefit plan. This footnote shall not apply if, in requesting a review, the provider does not furnish the information requested by BHS to make a utilization review decision, or if actions by the provider impede BHS's ability to issue a utilization review decision. BHS shall not deny benefits for a covered service, procedure, or treatment if:

1. The patient's provider, during normal business hours, contacts BHS on the day the patient is expected to be discharged, in order to request review of the patient's continued hospitalization, and BHS fails to provide a timely utilization review decision as stated above; or
2. The patient's provider makes at least three documented attempts during a four (consecutive) hour period to contact BHS during normal business hours in order to request review of a continued hospital stay, preauthorization of treatment for a patient who is already hospitalized, or retrospective review of an emergency hospital admission where the patient remains hospitalized at the time the review request is made, and BHS fails to be accessible.

[7] With respect to **members under non-grandfathered plans for plan years beginning on or after 7/1/2011:**

1. Any BHS notice of adverse benefit determination shall include information sufficient to identify the claim involved (including date of service, provider, and claim amount, if applicable). The reason(s) for the adverse benefit determination shall include the denial code and meaning, as well as a description of the standard, if any, that BHS used in denying the claim. **Effective only for plan years beginning on or after 1/1/2012**, such notice shall include a statement regarding the availability upon request, of the diagnosis code and treatment code, and their corresponding meanings.
2. BHS shall provide a description of available appeals and external review processes, including information how to initiate an appeal.
3. BHS shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under state or federal regulation to assist individuals with claims, appeals, and external review processes.
4. **Effective only for plan years beginning on or after 1/1/2012**, notices shall be provided in a culturally and linguistically appropriate manner as may be required by applicable state and federal regulations.

[8] With respect to **Kentucky** patients, any such notice shall be given in writing. A written notice in electronic format, including E-mail or facsimile, may suffice for this purpose where the member, authorized person, or provider has agreed in advance in writing to receive such notices electronically.

[9] With respect to **Kentucky** patients, written notice shall include:

1. The date of the review decision;
2. A statement of the specific medical and scientific reasons for denial or reduction in payment, or if the denial is based on coverage, identification of the provision of the schedule of benefits or exclusions that demonstrate that coverage is not available. The denial of a claim for failure to obtain pre-authorization is prohibited if the prior authorization requirement was not in effect and posted at the time of the date of service;
3. The state of licensure, medical license number, and the title of the reviewer making the decision;
4. A description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
5. Instructions for initiating or complying with the BHS appeal process, including whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations, or schedules, and the position and phone number of a contact person who can provide additional information.

[10] With respect to **Kentucky** patients, BHS's failure to make a determination and provide written notice within the prescribed time frames shall be deemed an authorization of the services requested, unless the failure to make the determination or provide the notice results from circumstances which are documented to be beyond BHS's control.

[11] With respect to **Tennessee** patients, adverse determinations shall be made by a psychiatrist possessing a valid license to practice medicine and who is board-certified or board-eligible or trained in the similar specialty as the health care provider who typically manages the medical condition or disease, or provides the health care service.

[12] With respect to **Kentucky** patients, access to BHS review staff shall be extended on Monday and Friday through 6:00 p.m., including federal holidays.