BEHAVIORAL HEALTH SYSTEMS

CLINICAL POLICIES

SUBJECT: CASE MANAGEMENT: REVIEW PROCESS – OUTPATIENT (NON-URGENT)

BOARD APPROVAL DATE: 08/19/92 **REVISED:** 10/27/93, 07/26/95
10/23/96, 10/22/97
01/01/02, 07/01/02
07/27/04, 08/30/04
08/01/06, 04/01/07
01/01/11, 04/01/11
01/01/12, 07/01/14
07/01/15, 05/01/19
11/01/19

PURPOSE:
1. To monitor the therapeutic process of treatment;
2. To evaluate treatment outcomes;
3. To monitor appropriateness of treatment in accordance with established guidelines;
4. To ensure quality of care;
5. To establish guidelines for approval of outpatient treatment by Care Coordinators.

POLICY: All BHS patient cases shall be routinely monitored and evaluated by the appropriate level of reviewer, i.e., Executive Vice President & MCO, Medical Director, Clinical Consultant, and/or independent physician reviewer, pursuant to the following procedure.

PROCEDURE:

I. Evaluation of the Therapeutic Process:

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 applicable plan, intensive outpatient programs, electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), and psychological testing are the only outpatient services for which Covered Members must obtain BHS' precertification. The absence of a precertification requirement does not affect BHS' right to determine the medical necessity of any outpatient service before, during or after care is rendered.

BHS encourages its Covered Members to call BHS prior to seeking non-emergency treatment regardless of whether precertification is required so that Covered Members and providers have:

1. Confirmation of the patient's benefit eligibility;
2. Verification that the diagnosis and/or requested services are a covered benefit under the client's benefit plan;
3. Knowledge of any Covered Member cost-sharing requirement before services are rendered and costs incurred;
4. An understanding of network and non-network providers for benefit application purposes;
5. Assistance in choosing the appropriate provider specialty area and specialist level for the patient's needs;
6. Discussion of preferences regarding appointment times, geographic locations, etc.; and
7. The assurance that BHS can promptly process claims and patient communication during the course of treatment.

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

Care Coordinators shall receive and review clinical assessments, treatment plans and progress notes, as necessary. BHS shall collect only the information necessary to certify the procedure or treatment and frequency or duration of services. BHS shall conduct its telephone and on-site information gathering reviews during providers' reasonable and normal business hours, unless otherwise mutually agreed. 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.

Cases reviewed will be evaluated for:

1. Completeness of data and timeliness of receipt.
2. Formulation and appropriateness of diagnosis (es).
3. Formulation and appropriateness of treatment plan including treatment goals.
4. Level of care prescribed.
5. Progress or non-progress toward treatment goals.
6. Revisions in treatment plan.
7. Frequency and duration of treatment services.
8. Adherence to policies regarding case manager/treatment provider interaction and responsibilities.
9. Conformance of treatment plan/progress to established BHS guidelines/protocols.
10. Accuracy and certification of claims.
11. Medical necessity based on formal review (see Attachment 3) by the Medical Director, clinical consultant or independent physician reviewer. If utilized, the physician reviewer will be board-certified in the same specialty or subspecialty of the attending physician when possible.

BHS shall not issue a non-certification based on initial screening.[1]

II. Authorization Procedure:

1. The Care Coordinator may approve up to two visits for an initial assessment by any BHS approved provider.

2. Beyond the initial assessment, approval of continued treatment will be based on the criteria delineated in BHS' Medical Necessity: Outpatient Treatment Criteria, Covered/Non-Covered Services and Conditions, and/or other applicable BHS policies.

3. Based on a review of the completed Assessment Report and Treatment Plan - Therapy, the Care Coordinator may approve continued treatment[2] beyond the initial assessment for any covered DSM diagnosis or V Code.

4. The Care Coordinator shall monitor the patient's response to outpatient treatment through verbal updates from the treating provider. The Care Coordinator may approve additional session(s) without requiring an updated clinical assessment/treatment plan and progress note documentation when:
    a. Outpatient treatment for a covered DSM diagnosis has not concluded by 9 post-assessment sessions and the provider anticipates the discontinuation of outpatient treatment within 3 additional visits; or
    b. Outpatient treatment for a covered V Code has not concluded by 3 post assessment sessions and the provider anticipates the discontinuation of outpatient treatment after 1 additional visit.

5. The case shall be referred to the Medical Director, independent physician reviewer, or clinical consultant, as appropriate, for review when:
    a. Therapy has extended beyond 10 post assessment sessions for a covered DSM diagnosis, or beyond 4 post assessment sessions for a covered V Code and the provider does not anticipate the discontinuation of outpatient treatment as described in II, 4 above.[3] The Care Coordinator shall notify the provider verbally and in writing of the need for an updated clinical assessment/treatment plan, and/or progress note documentation as necessary to determine the medical necessity of continued treatment. A copy of the written notification shall be sent to the Covered Member;
    b. Recommended frequency of visits is greater than weekly;
    c. Sessions are longer than 60 minutes for individual therapy, 60 minutes for family therapy, and/or 90 minutes for group therapy;
    d. The provider's initial estimated total number of sessions to complete treatment is incongruent with the documented diagnosis, symptom severity, level of impairment and/or goals for treatment;
    e. Treatment appears to be for a non-covered diagnosis or condition;
    f. The recommended level or intensity of care does not appear appropriate;
    g. The treatment goals do not appear clinically appropriate and/or achievable in the timeframes usually associated with treatment of the identified disorder;
    h. Psychiatric evaluation, substance abuse assessment or other assessment appears indicated; or
    i. Psychological testing is requested/recommended which exceeds the authorization guidelines in BHS' Medical Necessity: Psychological Testing.

6. The Care Coordinator may refer the patient for psychiatric evaluation at the time of intake or

upon receipt of the completed Assessment Report and Treatment Plan – Therapy in the event of any of the following:

a. Psychiatric evaluation is recommended by the provider performing the initial assessment.
b. The patient is prescribed medication(s) for a psychiatric condition by a non-psychiatrist and continued use of medication is indicated to treat the patient's reported condition.
c. The patient is diagnosed with one or more of the following conditions:
   Attention Deficit/Hyperactivity Disorder
   Schizophrenia (or any psychotic disorder)*
   Schizoaffective Disorder*
   Major Depressive Disorder*
   Bipolar I or II Disorder*
   Panic Disorder
   Obsessive Compulsive Disorder
   Posttraumatic Stress Disorder
   General Anxiety Disorder
   Dissociative Identity Disorder
   Anorexia Nervosa
   Intermittent Explosive Disorder

   *For these diagnoses, the Care Coordinator shall refer the case to the Medical Director if (i) the patient is not on medications and the provider is not recommending a medication evaluation; or (ii) the patient is refusing medications.

d. The patient is reported to have had prior successful treatment for a psychiatric disorder using medication(s) and is currently reported as having the same psychiatric symptoms or problems.

7. The Care Coordinator shall refer to the BHS Medication Management Authorization guidelines for all psychiatric/medication evaluation and continued medication management authorizations.

8. In instances where outpatient treatment is initiated without BHS approval, the Care Coordinator may approve the provider's submitted claim(s) provided all of the following are met:

   a. The treating provider meets BHS or plan criteria to render the services in question;
   b. The primary diagnosis on the claim(s) is a covered DSM-5 condition;
   c. The outpatient treatment provided does not require pre-authorization;
   d. There is no indication outpatient treatment is not contraindicated as the appropriate level of care for the primary diagnosis;
   e. The frequency of visits is not greater than weekly;
   f. Sessions are not longer than 60 minutes for individual therapy, 60 minutes for family therapy, and 90 minutes for group therapy; and
   g. The patient has not been seen for more than 10 post assessment sessions for a covered DSM diagnosis, or 4 post assessment sessions for a covered V-Code.

If the above criteria are not met, the Care Coordinator shall refer the case to the Medical Director, independent physician reviewer, or clinical consultant, as appropriate, for review. The Care Coordinator shall obtain all information needed to confirm the Covered Member is receiving treatment for a covered condition under the applicable client benefit plan, and to determine the medical necessity of treatment provided. In instances where a current clinical assessment/treatment plan and/or progress note documentation is needed, the Care Coordinator shall notify the provider verbally and in writing of the needed data. A copy of the written notification shall be sent to the Covered Member.

III. Pre-Authorization (and Concurrent) Review:[4] [5]

Precertification is not a guarantee of coverage; however, once certification is given, authorization shall not be withheld unless 1) clinical data does not substantiate information previously received, or 2) incomplete information was found to have been provided BHS, or 3) conflicting information was found in the clinical data. When conducting routine prospective and concurrent utilization review, BHS shall make its certification determinations based only on the information obtained by BHS at the time of the review determination. BHS shall make its determination and provide notice thereof within 15 calendar days of receiving a request to review a proposed Recommended Treatment Plan requiring a pre-authorization.[6] However:

A. If BHS does not receive all information necessary to complete the review, BHS will, within 5 days of receiving the request for review, notify the provider and enrollee or patient of the information that is needed. The parties shall have 45 days to provide such information. The 15-day review period shall be suspended during the time afforded the claimant to provide the necessary information. If a response is not received within the 45-day period or if the patient or provider refuses to release information to BHS, BHS will send written notification of its adverse benefit determination to the provider and enrollee or patient before the balance of the 15-day review period is exhausted.

B. BHS may request a 15-day extension to make its determination if (1) the extension is necessary for circumstances beyond BHS's control, and (2) prior to the end of the initial 15-day determination period, BHS notifies the claimant of the circumstances requiring the extension and the date by which it expects to make its determination.[7]

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.

IV. Retrospective Review:

If services have already been provided to the member, BHS shall complete any retrospective review of the services and provide notification of its determination within 30 days of receiving the request for review. BHS will make its determination based on the medical information available to the attending physician or ordering provider at the time the medical care was provided. If BHS does not receive all information necessary to complete the review, BHS will, at any time within 30 days of receiving the request for review, notify the provider and enrollee or patient of the information that is needed. The same 45-day period to provide necessary information discussed in paragraph II, A, above applies. BHS may also avail itself of the 15-day extension discussed in

paragraph II, B, above.

V. Notice of Benefit Determination:[8]

When a determination is made to certify a recommended treatment plan, the provider and the enrollee or patient shall be notified during their normal business hours by telephone or in writing.[9] Any party notified by telephone may request written confirmation as well. Written confirmation of certification for services shall include the number and type of approved services.

When a determination is made not to certify all or a portion of the recommended treatment plan (an adverse benefit determination), the provider shall be notified during his or her normal business hours by telephone and a written non-certification letter will be sent to the provider and the enrollee or patient.

Notice of an adverse benefit determination shall include[10]:

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.

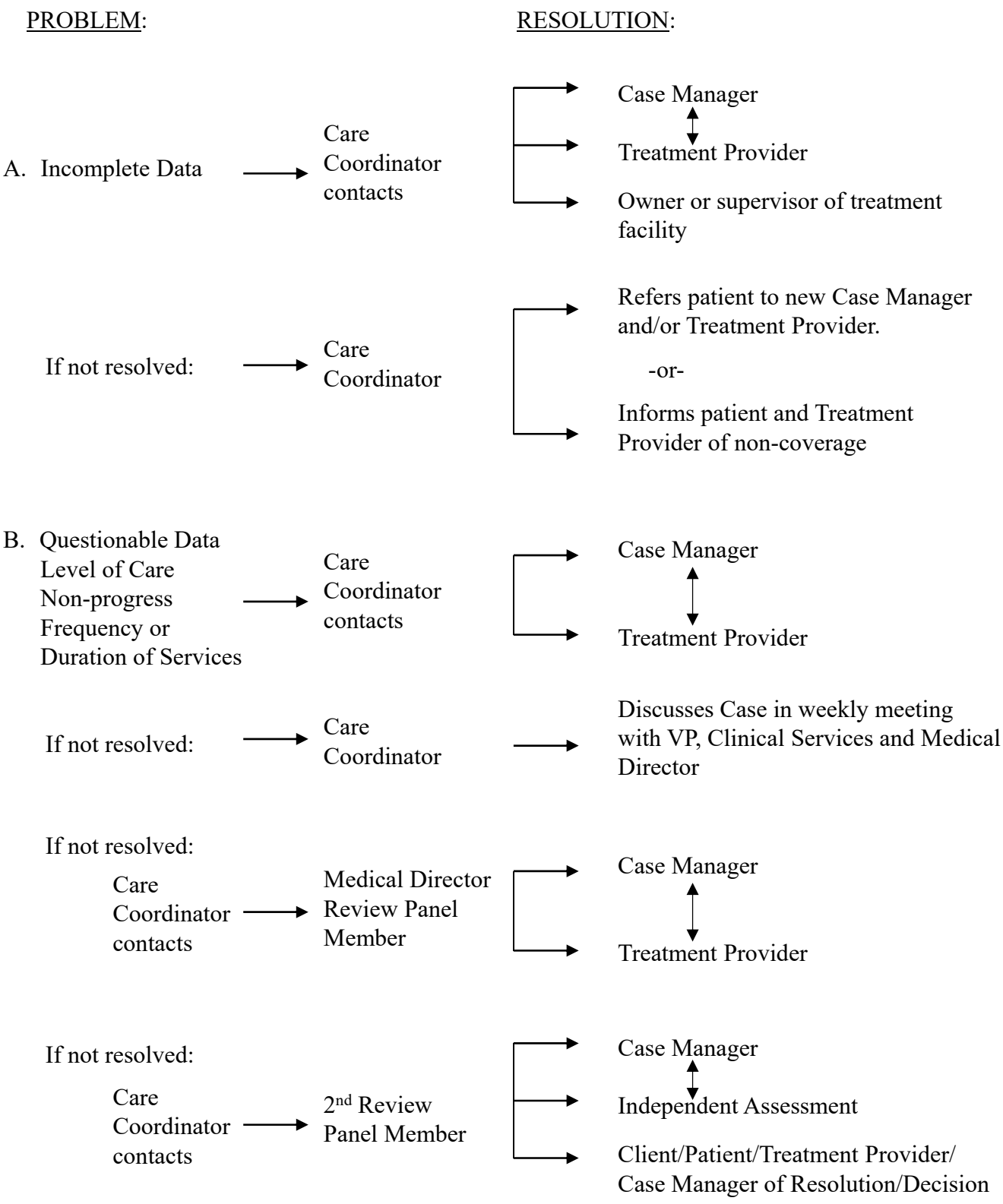
Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.

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

VI. Resolution of CONFLICTS/PROBLEMS:

Refer to Attachment A.

ATTACHMENT A
RESOLUTION OF CONFLICTS/PROBLEMS



[1] 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; or a psychologist possessing a valid license 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.

[2] With respect to **Tennessee** patients, the Care Coordinator shall authorize 12 visits beyond the initial assessment, or as otherwise recommended by the provider's treatment plan. Initial utilization review shall be limited to no more than a single page form to be submitted at the provider's preference via facsimile or internet and pursuant to applicable state and federal privacy and security statutes and regulations.

BHS shall limit additional information or follow-up utilization review to no more than 18% of the total number of outpatient reviews performed by BHS for the previous calendar year adjusted for the difference of Tennessee covered lives for the present calendar year, or as otherwise required by BHS' URAC accreditation. This 18% limitation shall not apply to utilization review applicable to at risk patients, patients seen more than 2 visits per week, and patients for which substance abuse is reported or suspected.

After such utilization review, the Care Coordinator shall authorize an additional 12 visits or as otherwise recommended by the provider's treatment plan.

Nothing in this section shall affect the plan or contract benefits.

[3] With respect to **Tennessee** patients, this provision is applicable only to at risk patients, patients seen more than two (2) visits per week, and patients for which substance abuse is reported or suspected.

[4] 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.

[5] 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.

[6] With respect to **Kentucky** patients, BHS's failure to make a determination and provide written notice within 5 days of a request and obtaining all necessary information 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.

With respect to **Alabama, Indiana, or Tennessee** patients, BHS shall provide written notification of its certification decision to the provider 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 provider 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 (one business day if the decision is to extend a previously approved recommended treatment plan), of receipt of all necessary information, if earlier.

[7] With respect to **Indiana** patients, this 15-day extension is not available to BHS.

[8] 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 1/1/12012**, notices shall be provided in a culturally and linguistically appropriate manner as may be required by applicable state and federal regulations.

[9] With respect to **Indiana** patients, such notification shall be sent within two working days of receiving all necessary information.

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.

[10] 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. Except for retrospective review, 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.