North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

Improving the mental health and well being of individuals and families in our communities

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NSMHA Contract Memorandum 2015-001

Date: January 8, 2015

To: Tom Sebastian, Compass Health and Compass Whatcom
Donna Konicki, Bridgeways
Michael Watson, Lake Whatcom RTC
Will Rice, Catholic Community Services Northwest
Claudia D'Allegri, Sea Mar
Ken Stark, Snohomish County Human Services Director
Phil Smith, Volunteers of America
Cindy Paffumi, Interfaith
Sue Closser, Sunrise Services
Robert Sullivan, Pioneer Human Services
Dr. Jerry Jenkins, NWESD 189
Beratta Gomillion, Center for Human Services

From: Joe Valentine, Executive Director

Subject: Revised Policy

Policy 1505.00 – Authorization for Ongoing Outpatient Services

This policy has been through the complete review and approval process. The Executive Director signed and approved this policy January 7, 2015.

Full implementation of this policy should occur no later than 60 days after this memo.

cc: Cindy Ferraro, Bridgeways
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Contract File

Effective Date: 8/29/2014; 3/31/2008; 3/8/2007
Revised Date: 12/3/2014
Review Date: 12/3/2014

North Sound Mental Health Administration

Section 1500 – Clinical: Authorization and Re/Authorization for Ongoing Outpatient Services

Authorizing Source: CFR 438.210; MHD Contract 2007-09; Provider Contract 2007-09
Cancels:
See Also:
Approved by: Executive Director
Date: 1/7/2015
Responsible Staff: Quality Manager
Signature:

POLICY #1505.00

SUBJECT: AUTHORIZATION AND REAUTHORIZATION FOR ONGOING OUTPATIENT SERVICES

PURPOSE

To outline how individuals in need of outpatient mental health services from North Sound Mental Health Administration (NSMHA) contracted Behavioral Health Agencies (BHAs) are authorized or reauthorized (re/authorization shall mean both processes throughout the remainder of the policy) to receive medically necessary services in order to ensure consistent application of NSMHA's re/authorization processes.

POLICY

Individuals requesting NSMHA re/authorization for mental health services must first meet financial eligibility criteria. Individuals who have Washington Apple Health with a Regional Support Network benefit identified, per ProviderOne, are considered financially eligible. For individuals who do not have this benefit, see NSMHA Policy 1574 State Only Funding Plan – Mental Health Services regarding financial eligibility for services.

For individuals who have made an initial request for service and have had an intake with a NSMHA-contracted BHA for which NSMHA is the payer, NSMHA shall review an authorization request when the BHA substantiates the individual meets financial eligibility, Washington State Access to Care Standards (per DSHS contract) and medical necessity criteria. Per DSHS contract, medical necessity means:

1. The requested service is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
2. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the individual requesting service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all.
3. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness covered by Washington State for public mental health services.
4. The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a covered mental illness.
5. The individual is expected to benefit from the intervention.
6. The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

For individuals who are currently in an open outpatient episode and current authorization period for which NSMHA is the payer, NSMHA shall review a reauthorization request when the BHA substantiates the individual meets financial eligibility and NSMHA Continued Stay Criteria as follows:

1. Continues to meet the Washington State Access to Care Standards (ACS) diagnosis and Global Assessment of Functioning (GAF)/Children's Global Assessment Scale (CGAS) criteria (B qualifiers not applicable) **and all** components of medical necessity:

    a. The individual's impairment(s) and corresponding need(s) must be the result of the mental illness.
    b. The intervention is deemed reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
    c. The individual is expected to benefit from the intervention.
    d. The individual's unmet need(s) would not be more appropriately met by any other formal or informal system or support.

And/or one or more of the following:

1. Individual is engaged in a transition to discharge plan. If the transition plan is successful, the individual will be discharged from the episode of care within 90 days of the initiation of the transition to discharge plan. If the individual's condition changes during the course of the transition, such that continued treatment is determined to be medically necessary, a review of the Recovery/Resiliency Plan will occur and a revised plan will reflect the purpose of ongoing care.
2. Although the individual's functioning has improved and exceeds the GAF/CGAS standard, continued treatment is deemed medically necessary to prevent deterioration as evidenced by previous documented unsuccessful efforts at discharge.
3. Although the individual's functioning has improved, they have needs, which cannot be met by any other system or resource other than NSMHA-funded mental health and, if unmet, would result in deterioration of functioning and likely re-admission.
4. Individual has a current Less Restrictive (LR) Court Order or Conditional Release (CR) in place.

Role of Provider (each NSMHA contracted provider will):

1. Comply with NSMHA mechanisms to ensure consistent application of review criteria for re/authorization decisions, including consultation with NSMHA when appropriate.
2. Identify, define and specify the amount, duration and scope of each service the individual will receive in collaboration with the individual.
3. Provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
4. Ensure services are provided in accordance with NSMHA's level of care guidelines as medically necessary and are not arbitrarily denied or reduced, (for example, the amount, duration, or scope of a required service) based solely upon diagnosis, type of mental illness, or the individual's mental health condition.
5. Submit requests and supporting documentation in a timely manner so NSMHA may comply with specified timeframes for decisions as required by federal and state standards.

Role of NSMHA:

1. Ensure consistent application of review criteria for authorization decisions and not arbitrarily deny a service authorization request.
2. Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
3. Not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or mental health condition of the individual.
4. Ensure authorization of a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the individual's condition or disease.

5. NSMHA will comply with specified timeframes for decisions as required by federal and state standards.
6. NSMHA will provide for standard and expedited re/authorization decisions and notices per required timeframes.
7. NSMHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization management, provided the services furnished can reasonably be expected to achieve their purpose, as required by federal and state standards. NSMHA and its contractors will consider what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the Washington Apple Health program as indicated in State statutes and regulations, the State Plan and other State policy and procedures. NSMHA, in accordance with these regulations, is responsible for covering services related to the following:

    a. The prevention, diagnosis and treatment of health impairments.
    b. The ability to achieve age-appropriate growth and development.
    c. The ability to attain, maintain, or regain functional capacity.

8. NSMHA will ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any individual.

PROCEDURE

Authorization

Based upon information from the completed intake assessment, the provider requests from NSMHA either authorization or adverse determination.

Request for Authorization

1. If, upon completion of the intake assessment, the BHA clinician believes ACS and medical necessity are met, the BHA shall transmit a completed electronic request for authorization per NSMHA data dictionary including, but not limited to: diagnoses, eligibility criteria, and identified Level of Care to NSMHA. If necessary, NSMHA staff will request additional clinical information to justify the authorization.

    a. Standard authorization requests shall be sent to NSMHA within 14 calendar days of the individual's request for service. If the assessing clinician cannot complete the initial assessment within the first 14 calendar days, the individual or the assessment clinician may request an extension of up to an additional 14 calendar days.
    b. For expedited authorizations, phone notification shall be made to NSMHA (360-416-7013) to alert them to the need for immediate review. Phone notification shall be followed by faxing the authorization request and assessment to NSMHA (360-416-7017) for review within 3 working days of the individual's request for service. Expedited authorization requests (electronic) must be sent to NSMHA in addition to the phone and fax process. This timeframe may be extended by an additional 14 calendar days if requested by the individual consumer.
    c. If a diagnosis is Provisional, per Diagnostic and Statistical Manual (DSM) standards, this identification must be included in the electronic authorization request. This information should be included in the "Additional Information to Consider" field of the Additional Authorization Information transaction and should identify the specific diagnosis and diagnosis code that is provisional.

d. State funded individuals need the following additional information to accompany the request:

    i. Identification of priority population category per NSMHA Policy 1574.
    ii. Explanation for any requested authorization period longer than three (3) months.

2. All persons who meet the financial criteria, ACS and medical necessity criteria are authorized by NSMHA within 1 business day of the receipt of the authorization request whenever possible or, at the most, within 14 calendar days of receipt of the request. NSMHA will notify the individual and provider of all authorizations and their benefits.

    a. If authorized, the person is accepted into services and appropriate appointments are made as expeditiously as the individual's health condition requires with the first ongoing appointment to occur no later than 28 calendar days from the request for service.
    b. There are some services that require additional criteria be met and/or may not be available immediately due to capacity limitations (e.g., Residential, Program for Assertive Community Treatment (PACT), Intensive Outpatient Program for Adults (IOP), WISe (Wraparound with Intensive Services)).
    c. Authorization periods do not exceed one year. The following groups of individuals will be authorized for the period specified:

        i. State funded individuals – see NSMHA Policy 1574.
        ii. Individuals with Washington Apple Health who are identified as needing services at a Level of Care (LOC) 1 or 2 at the initial authorization are authorized for a period up to 6 months.

    d. The requested authorization start date may not precede the first day of the month prior to the month the authorization request is received. Any requests received with an earlier start date shall be modified by NSMHA.

3. If NSMHA reviewers deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested, they will notify the requesting provider and give the individual written notice in sufficient time to ensure state-established timeframes are met.

    These decisions will be made by a NSMHA staff who meets the requirements of a Mental Health Professional (MHP) and who has appropriate clinical expertise to make the decision.

Request for Adverse Determination

1. If, upon completion of the intake assessment, the provider believes ACS and medical necessity are not met, they will send the intake assessment form, Access call sheet and any other available documentation or medical records reviewed in the assessment process to NSMHA staff with the completed NSMHA Denial Review Request form within 14 calendar days (standard) or within 3 working days (expedited) from the initial request for service.
2. NSMHA staff will review the documentation and determine whether or not to authorize services.

    a. If services are authorized, NSMHA staff will notify the individual and provider of the decision to authorize services. The individual will be notified of their benefit package.
    b. If no services are authorized, NSMHA will notify the requesting provider and give the individual written notice in sufficient time to ensure state-established timeframes are met.

Reauthorization

While the MHCP and individual review progress toward the individual's Recovery/Resiliency Plan (RPP) goals routinely throughout the course of treatment, for individuals whose current authorization is about to expire, the MHCP must ensure the RRP review is conducted within 45 days of the current authorization's expiration. Based upon this review, the MHCP shall determine reauthorization of services is warranted or determine transition to discharge should begin if it hasn't already.

Request for Reauthorization

1. If, upon completion of the RRP review, the provider believes Continued Stay Criteria are met, they will transmit a completed electronic request for reauthorization per NSMHA's data dictionary including, but not limited to: diagnoses, eligibility criteria and identified Level of Care to NSMHA within the two (2) week period prior to the expiration of the current authorization. If necessary, NSMHA staff will request additional clinical information to justify the reauthorization.

    a. If a diagnosis is Provisional, per DSM standards, this identification must be included in the electronic reauthorization request as noted in the request for authorization above. However, it should be noted provisional diagnoses are generally expected to be clarified by the reauthorization request.
    b. State funded individuals need the following additional information to accompany the request

        i. Identification of priority population category per NSMHA Policy 1574.
        ii. Explanation for any requested reauthorization period longer than three (3) months.

2. All persons who meet the financial criteria and Continued Stay Criteria are reauthorized by NSMHA within 1 business day of the receipt of the reauthorization request whenever possible or, at the most, within 14 calendar days of receipt of the request. NSMHA will notify the individual and provider of all reauthorizations and their benefits within 14 calendar days of the decision.

    a. There are some services that require additional criteria be met and/or may not be available immediately due to capacity limitations as noted previously in the request for authorization above.
    b. Reauthorization periods do not exceed one (1) year. The following groups of individuals will be reauthorized for the period specified:

        i. State funded individuals – see NSMHA Policy 1574.
        ii. Individuals with Washington Apple Health identified as needing services at a LOC 1 or 2 shall be authorized for a period up to 6 months.

    c. The requested start date of a reauthorization may not precede the first day of the month prior to the month the reauthorization request is received. Any requests received with an earlier start date shall be modified by NSMHA.

3. If NSMHA reviewers deny a service reauthorization request or reauthorize a service in an amount, duration, or scope that is less than requested, they will notify the requesting provider and give the individual written notice in sufficient time to ensure that state-established timeframes are met.

    These decisions will be made by a NSMHA staff who meets the requirements of a Mental Health Professional (MHP) and who has appropriate clinical expertise to make the decision.

Discharge from Treatment

If, upon completion of the RRP review, the MHCP believes Continued Stay Criteria are not met, the MHCP shall transition the individual toward planned discharge per NSMHA Policy 1540 Discharge from Treatment.

If the individual doesn't agree with planned discharge, see NSMHA Policies 1551 Recovery/Resiliency Plans and 1005 Notice Requirements for additional information.

Timelines for Standard and Expedited Re/authorization Decisions

Standard re/authorization decisions

For standard re/authorization decisions, provide notice as expeditiously as the individual's health condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of request for service (for reauthorizations this is 14 calendar days following receipt of the reauthorization request), with a possible extension of up to 14 additional calendar days*, if the individual or the provider requests extension. NSMHA will automatically approve without advance notice any extension request by an individual or provider. An extension may also be obtained if NSMHA justifies (to the Department of Social and Health Services (DSHS) upon request) a need for additional information and how the extension is in the individual's interest.

Expedited re/authorization decisions

For cases in which a provider indicates, or NSMHA or its designee determines that following the standard timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, NSMHA must make an expedited re/authorization decision and provide notice as expeditiously as the individual's health condition requires and no later than 3 working days following receipt of the request for service (for reauthorization this is 3 working days following receipt of the reauthorization request). NSMHA may extend the 3 working days' time period by up to 14 calendar days if the individual requests an extension*. NSMHA will automatically approve, without advance notice, any extension request by an individual or provider. An extension may also be obtained if NSMHA justifies (to DSHS upon request) a need for additional information and how the extension is in the individual's interest.

*When calculating the number of days from the request for service, the first day is the day after the request for service. For example, the request for service is received on January 14th a standard decision must occur by or on January 28th. For a request that comes in on a Thursday and is identified as expedited, the assessment and authorization decision must be completed by the end of the following Tuesday.

Extensions

Extensions are expected to be utilized only in rare circumstances and must be of benefit to the individual. When an extension is utilized, the BHA must document a rationale for the extension in its re/authorization (in the Additional Authorization Information transaction) or adverse determination request (on the Denial Review Request form) to NSMHA. NSMHA will monitor the use and pattern of extensions and apply corrective action where necessary.

Change in Mental Health Coverage

Attainment of Coverage

For individuals who become NSMHA-eligible while already in treatment with a provider agency, a current diagnostic justification must be present in the clinical record. The current assessment and RRP must meet or be updated to meet DSHS and NSMHA standards. Authorization for services will be submitted to NSMHA within 14 days of the time the provider becomes aware of the change in payer/NSMHA

eligibility. Providers are responsible for ensuring the appropriate funding source is charged for services depending upon the individual's financial eligibility.

Loss of Coverage or Change in Payer

For individuals for whom NSMHA is no longer the payer*, the BHA must request termination of NSMHA authorization by the 10th of the month following the discontinuation of NSMHA as payer. In addition, the BHA shall not submit encounters' to NSMHA from the date the BHA determines NSMHA is no longer the payer.

*NSMHA is the payer as identified in ProviderOne or when the individual is eligible for use of NSMHA state funds (see NSMHA Policy #1574).

To request a termination of a current NSMHA authorization, the BHA sends a 278 Authorization Request transaction. Upon receipt of this request, NSMHA shall terminate the authorization and send a Notice to the individual.

ATTACHMENTS

None