

 <p>SPOKANE COUNTY Regional Support Network Prepaid Inpatient Health Plan</p>	Policy Title: Outpatient Authorization		Policy # CS0 -1
	Signature: Signature on file		Revised: 9/5/07
	Christine Barada, Director Community Services, Housing and Community Development		Reviewed: 9/10/07
	Signature Date: 9/5/07		Signing by authority of Res. No. 2007-0038

Applies to:

Internal External

References

42 CFR 438.210 3 c
CFR 438.210 d
RCW 71.24,
WAC 388-865,
Medicaid Waiver 1915 b Sec A.IV.c.2.a.i

Scope

SCRSN/PIHP and its contracted providers.

Policy

SCRSN/PIHP and subcontractors shall utilize a standard protocol for obtaining authorization for enrolled Spokane County Regional Support Network (SCRSN) consumers for routine outpatient (community support) services.

Definitions

Authorization: A decision made by the SCRSN or designee that a request for routine outpatient mental health services meets the criteria for medical necessity. The authorization is for covered services for Medicaid eligible Title XIX consumers or for Medicaid consumers eligible for the non-medicaid benefit package and the consumer must be eligible for an approved state modality for the requested level of care.

Denial: The decision by the SCRSN or designee not to authorize covered Medicaid mental health services that meet the Access to Care Standards of the Mental Health Division. The decision not to authorize covered Medicaid mental health services is due to lack of medical necessity/eligibility criteria. An enrollee who objects to a net work provider deciding not to provide a covered service may request a second opinion or file a grievance.

Procedures/Mechanisms

SCRSN/PIHP will require network providers comply with the above referenced laws regarding authorization for services which includes the following:

General Authorization

Outpatient services are designed for SCRSN Title XIX eligible consumers. Prior approval is not required for intake but is required before on going outpatient services are provided and may be subsequently authorized for the service period of 1-180 calendar days. Providers will submit data to the SCRSN within 5 days of any encounter. An authorization is issued for 1-180 days from the date of first service. The authorization process involves a clinical review for meeting medical necessity, Title XIX eligibility and a data review for completeness.

Outpatient Service Authorization

1. **Outpatient services** are designed for SCRSN Title XIX eligible consumers. Prior approval is required and must be subsequently authorized for the initial service period of 180 calendar days or any confirmed updated data requirements of the MHD. Providers will submit data to the SCRSN or designee within 5 days of any encounter. An outpatient authorization is issued for 180 days from the date of first service. The authorization process involves both a clinical review of the five Axis' for meeting medical necessity, Title XIX eligibility and a data review for completeness.
 - 1.1 Timeframes for processing authorization requests are the following:
 - 1.1.2 **Standard authorizations:** No longer than 14 days following the receipt of the request unless either the consumer or the MHCP request an extension. The extension may not exceed an additional 14 days or a total of 28 days.
 - 1.1.3 **Expedited authorizations:** Authorizations reviewed within 72 hours of receipt. Expedited authorizations are utilized if the standard authorization timeframe could seriously jeopardize the consumer's life, health or ability to attain, maintain or regain maximum function. The 72 hour expedited authorization may be made by either the MHCP or the SCRSN. The expedited authorization must be processed with in 72 hours. This period may be extended for up to 14 calendar days if the enrollee or the MHCP requests the extension and is able to justify how the extension benefits the consumer.
2. **Ancillary Authorizations Requests** are for SCRSN consumer's who are currently enrolled with a Responsible Agency.

Note: Examples of Ancillary services include but are not limited to: Residential Care, medication management, supported living and CLIP placement. Consumers must be enrolled with a Responsible Agency. Ancillary Authorizations are approved for 180 days.
3. **Medication Management services** are designed for SCRSN Title XIX consumers. Prior approval is not required for intake but is required before on going outpatient services are provided and subsequently authorized for the initial service period of 365 calendar days. Providers will submit data to the SCRSN or designee within 5 days of any encounter. An outpatient authorization for medication management services is issued for the 365 days from the date of first service. The authorization process involves both a clinical review of the five Axis' provided by the enrolled responsible agency for medical necessity, Title XIX eligibility and a data review for completeness.

Note: Medication management may be authorized as either an ancillary or primary service.

3.1 Timeframes for processing authorization requests are the following:

- 3.1.1 **Standard authorizations:** No longer than 14 days following the receipt of the request unless either the consumer or the MHCP request an extension. The extension may not exceed an additional 14 days or a total of 28 days.
- 3.1.2 **Expedited authorizations:** Authorizations reviewed within 72 hours of receipt. Expedited authorizations are utilized the standard authorization timeframe could seriously jeopardize the consumer's life, health or ability to attain, maintain or regain maximum function. The 72 hour expedited authorization may be made by either the MHCP or the SCRSN. The expedited authorization must be processed with in 72 hours. This period may be extended for up to 14 calendar days if the enrollee or the MHCP requests the extension and is able to justify how the extension benefits the consumer.

Utilization Management Review

- 4. The SCRSN or designee review of authorization requests will involve the following:
 - 4.1 A review of the consumers completed authorization request.
 - 4.1.1 A history of service utilization, intensity and duration of services,
 - 4.2 A level of care determination if applicable.
 - 4.3 On initial authorizations for 180-day outpatient services, the SCRSN or designee will also consult the Access to Care Standards to ensure that the request falls within established guidelines.
 - 4.3.1 A summary of any additional information shall be documented in the note field of the authorization request screen. Examples of additional information include documentation of coexisting conditions, justification of "B" diagnosis or Special Programs and need for intensity of service.
 - 4.4 Failure of the provider to respond to a pended authorization will result in a denial of the authorization after 14 calendar days from the pended status date.
 - 4.4.1 A consumer, or provider, may request, and be granted an extension of the fourteen (14) day timeframe for the standard services authorization of up to fourteen (14) additional days and an extension of the three (3) day timeframe for the expedited services authorization of up to fourteen (14) additional days
 - 4.4.2 The SCRSN may request and be granted an extension of the fourteen (14) day Timeframe for the standard services authorization of up to fourteen (14) additional days, subject to the approval of the MHD and an extension of the three (3) day timeframe for the expedited services authorization of up to fourteen(14) additional days subject to the approval of the MHD
NOTE: If the SCRSN or designee elects to grant an extension of either timeframe, the SCRSN or designee must notify the consumer or responsible party, giving the reasons for the delay and extension and informing the consumer of the right to file an appeal if he/she

disagrees with the extension, and the SCRSN or designee must utilize the period of extension as expeditiously as possible, and as the consumer's health status requires. The contact is documented in the MIS system in the request for authorization.

Telephonic Utilization Management Review

5. The SCRSN or designee will conduct telephonic care management reviews with the mental health care provider (MHCP) if an authorization request requires discussion or clarification. The SCRSN or designee, through additional documentation gathered, may approve the request as presented or request additional documentation for peer review. The SCRSN or designee or if needed the Medical Director will be consulted, review any request and render an authorization or denial decision. The provider will be notified by the MIS regarding the outcome of the request.
 - 5.1 If the authorization is denied due to not meeting medical necessity a Notice of Action will be issued by the SCRSN or designee to the consumer.
6. Each enrollee receives written notice of any decision by the, SCRSN or designee to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For SCRSN or designee, the notice must meet the requirements of CFR 42 Sec. 438.404, except the notice to the provider need not be in writing.
 - 6.1 Timeframe for decisions. Contracted providers must provide for the following decisions and notices;
 - 6.1.1 Standard authorization decisions. For standard authorized decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days,
if
 - 6.1.2 The enrollee, or the provider, requests extension;
or
 - 6.1.3 The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
 - 6.2 If the consumer wishes to appeal a Notice of Action, they or their advocate should refer to and follow the procedure outlined in the Appeal Policy.

Exceptions to the Advance Notice Requirements.

7. The SCRSN may mail a Notice of Action not later than the date of the action, in the case of the following occurrences (CFR 431.213):
 - 7.1 the death of a consumer;
 - 7.2 a consumer no longer desires services;

- 7.3 a consumer has been admitted to an institution and becomes ineligible for services;
- 7.4 a consumer's whereabouts becomes unknown;
- 7.5 the consumer has been accepted for Medicaid services in another jurisdiction, or
- 7.6 any of the other three (3) exceptions listed in the federal statute (CFR 431.213(f)(g)(h)). **NOTE:** If a consumer's services are discontinued due to his/her unknown whereabouts, the services must be reinstated if his/her whereabouts becomes known during the time when he/she is eligible for services (CFR 431.231(d)).
- 7.7 If the consumer wishes to appeal a Notice of Action they or their advocate should refer to and follow the procedure outlined in the Appeal Policy.

Content of Care Management Review

- 8. The SCRSN or designee utilization review may include the following:
 - 8.1 A review of the consumer's diagnosis, level of functioning, acuity, any co-existing conditions, involvement in medication management, and co-existing medical conditions.
 - 8.2 Clinical review of family history and systems, formal and informal supports.
 - 8.3 Medical, developmental, behavioral and mental health history including risk factors such as recent hospitalizations.
 - 8.4 History of service utilization and intensity, duration of services, targeted outcomes and objectives.
 - 8.5 Treatment plan and crisis plan.
 - 8.6 Summary of proposed strategies and interventions planned to achieve outcomes in the forthcoming period while addressing factors that created barriers to care, discharge planning and transition to use of natural supports within the previous authorization period.
 - 8.7 An assessment of age, culture and broader community culturally diverse support systems, including consultation with specialists.
 - 8.8 Title XIX eligibility.

Authorization Documentation

- 9. After the authorization request has been reviewed, and all questions or concerns have been addressed and documented, the disposition of the authorization request is entered into the authorization screen on the MIS and transmitted to the agency electronically within two business days. Provider agencies may review the authorization and call the

SCRSN or designee if they have questions or wish to initiate the appeal process for the consumer at a higher level.

Monitoring

This policy will be monitored through the annual contracted provider monitoring, with the appropriate recommendations, findings and/or corrective actions required in performance improvement projects.

Reference:

CS-22 Second Opinion

QM- 13 Appeals

CSI-9 Community Reintegration