TITLE: **Authorization and Utilization Management (UM) Policy**
DATE PUBLISHED: **June 29, 2012**
EFFECTIVE DATE: **July 1, 2012**

PURPOSE:

Salt Lake County Division of Behavioral Health Services (DBHS) is committed to the provision of services for individuals with a Substance Use Disorder (SUD). Salt Lake County believes in the provision of individualized services aimed at meeting the distinct needs of each consumer. All services delivered are based on medical necessity, provided to the consumer when they need it and provided at the established level as outlined by American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R).

Research reflects the number of individuals and families affected by substance abuse have increased since the early 1990's and that, unfortunately, the availability of and financing for substance abuse services have not kept pace with the needs. Salt Lake County is not an exception with consumers seeking services only to find waiting lists with County contracted providers. OptumHealth and Salt Lake County's Authorization and Utilization Management Policy seeks to increase oversight for Medicaid and County funded treatment to ensure that high quality, cost-effective SUD services and resources are delivered consistent with the needs of the consumer, in the least restrictive setting based on ASAM PPC-2R, promoting equitable access to care.

Utilization Management goals are:

1. To ensure the effective and efficient utilization of substance use services within Salt Lake County through prospective, concurrent and retrospective review.
2. To continually assess and improve access and quality of care for consumers.
3. To ensure Contractor compliance with all applicable State, Federal and County requirements.
4. To coordinate and transition care when a consumer will benefit from continued treatment at another level of care or with another Contractor.

DEFINITIONS:

Action: Includes any of the following circumstances listed:

- The denial or limited authorization of a requested service, including the type or level of service;
- Service authorization decisions not reached within required time frames;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner-as defined as failure to meet performance standards for provision of first face-to-face services when due to provider limitations and the consumer is dissatisfied with this;
- The failure of OptumHealth, DBHS or IGS to act within the time frames established for resolution and notification of appeals and grievances.

Appeal: an appeal is the Contractor or consumer's request to review OptumHealth's, DBHS or IGS's action to determine if the appropriate decision was made regarding the case for which action was taken.

- In order to file an appeal, a Notice of Action must be issued. A copy of this Notice of Action must accompany the appeal.
- The consumer or provider may file an appeal either orally or in writing.
- The consumer's provider may file the written, signed appeal on behalf of the consumer and must include the consumer's signed written consent.

Continued Services When Case is Under Appeal: A consumer has the right to continue receiving services if:

- the Action taken on the part of OptumHealth, DBHS UM or IGS was to reduce, suspend or discontinue authorization of services that had been *previously* approved;
- the original period covered by the original authorization has not expired;
- the appeal was filed within the required time frame, **AND**
- the request being submitted is in regards to continuation of services*****Please Note –** If the appeal decision is NOT in the consumer's favor, the consumer may be responsible for the services received or delivered while appeal was pending. If the appeal involves any action other than request for continued services, services will and should automatically continue as they are.

ASAM PPC-2R: American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders. For this document, "ASAM" will be used when referring to ASAM PPC-2R

IGS: University of Utah's Assessment & Referral Services/Interim Group Services staff in the role of Utilization Management Care Advocate.

ARS/IGS: University of Utah's Assessment & Referral Services/Interim Group Services providing comprehensive assessments and pretreatment groups.

Care Advocate: Utilization management staff at OptumHealth, DBHS UM and IGS

Concurrent Review: A review that evaluates continued medical necessity and timeliness of the plan of care from the time of assessment, admission and services provided through discharge.

Contractor: an agency under contract with Salt Lake County Division of Behavioral Health Services to provide treatment for substance use disorders.

DBHS UM: Division of Behavioral Health staff in the role of Utilization Management Care Advocate.

DBHS QA: Division of Behavioral Health staff who facilitate and manage the appeal process as outlined in this Policy. Staff participating in a role as care advocate will not also oversee the appeal.

Discharge Criteria: criteria needing to be present to demonstrate that the consumer is ready to move to a lower level of care or terminate services.

Discharge Plan: defining the preparation necessary to facilitate the move of the consumer to a lower level of care enhancing the continuum of care or to facilitate successful completion of services.

Denial: a refusal to satisfy a request.

Imminent Danger: as defined by problems in multiple areas (health, mental health, and substance use) that can lead to grave consequences to the consumer or others. Three components constitute imminent danger:

a. a high probability that certain behaviors (such as continued alcohol or drug use or relapse) will occur;
b. the likelihood that such behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while under intoxicated); and
c. the likelihood that such adverse events will occur in the very near future.

The concept of imminent danger *does not* encompass all the possible things that may happen, but is restricted to the combination of the three factors above. On the other hand, the interpretation of imminent danger should not be restricted to acute suicidality, homicidality, or medical or psychiatric problems that create an immediate, catastrophic risk.

Medical Necessity: Any substance use service that is necessary to diagnose, correct or ameliorate a substance use disorder or prevent deterioration of that substance use disorder or development of additional health problems and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

Notice of Action: Written notification of a consumer and written or verbal notification of a provider when applicable, of an action that will be taken by OptumHealth, DBHS UM or IGS.

Notice of Appeal Resolution: Written notification of a consumer and a provider when applicable of the County's resolution of an appeal.

Prospective Review: A review of the assessment to evaluate the medical necessity of treatment and determine whether services are to be initially authorized.

Retrospective Review: A review of services rendered to a consumer on a case-by-case or aggregate basis after the services have already been provided.

Substance Use Disorder: A disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)

POLICY PROVISIONS:

Submission Process

A request for authorization will be submitted based on funding source or Contractor providing services. Care Advocates at OptumHealth, DBHS UM or IGS will coordinate all prospective, concurrent and retrospective reviews.

- Medicaid eligible services are authorized by OptumHealth by phone at 1-877-370-8953 for ASAM Level II.1 or higher
- Medicaid eligible services will be opened by the provider in ProviderConnect for ASAM Levels 0.5 and 1.0
- County block grant services require authorization through DBHS UM or IGS for ASAM Level II.1 care or higher
    - Requests submitted to DBHS UM will be submitted by email to bhauthorization@slco.org
    - Requests submitted to IGS are to be coordinated through IGS Care Advocates by phone or email
- County block grant will be opened by provider in UWITS for I.0, III.2D, or CATS services and will not require pre-authorization
- When a consumer is participating in Drug Offender Rehabilitation Act (DORA), Family Dependency Drug Court (FDDC), Juvenile Drug Court (JDC), Criminal Justice Services (CJS), or other Special Revenue Sources they require authorization through DBHS regardless of their funding source and ASAM Level
    - Requests for FDDC will be submitted by email to FDDC Coordinator
    - Requests for DORA or CJS will be submitted by email to DORA Coordinator
    - Requests for JDC will be submitted by email to JDC Coordinator

Authorization hours are as outlined with the exception of legal holidays:

- OptumHealth's personnel are available to receive calls from 8:00 a.m. to 5:00 p.m. Monday through Friday;

- DBHS UM's personnel are available to receive calls from 7:30 a.m. to 4:30 p.m. Monday through Friday; and
- IGS's personnel are available to receive calls from 7:30 a.m. to 4:30 p.m. Monday through Friday.

Prospective Review

The prospective review includes the initial authorization for treatment services. Prospective reviews evaluate the medical necessity of proposed services to determine admission into treatment. Prospective Reviews are mandatory requiring pre-authorization, for the following ASAM levels of care: II.1, II.5, III.1, III.3 and III.5. All prospective review authorizations require the completion of a comprehensive assessment, as defined by Salt Lake County DBHS, to evaluate and confirm medical necessity. Prospective reviews fall into one of the following categories:

1. If the assessment is completed by ARS/IGS or Salt Lake County Outreach the prospective review requirement for pre-authorizing is satisfied and services are authorized at the level of care recommended by the assessor. For Medicaid consumers the Contractor will contact a care advocate at OptumHealth who will provide an authorization code to be entered into UWITS. For County or Special Revenue Sources the Contractor will contact the care advocate assigned to the population (DBHS UM or IGS) to have the authorization entered into UWITS when the consumer begins services.

2. If the Contractor is requesting authorization for treatment following an assessment completed by their own agency, the Contractor will Consent and Refer the client's profile, the County approved assessment and a miscellaneous note containing the authorization request to the appropriate care advocate (OptumHealth, DBHS UM or IGS). The contractor will select "yes" in the actual miscellaneous note when asked if the Contractor wants to release the note. Once the required information is released the Contractor will contact the care advocate to complete the authorization by phone.

3. If the Contractor determines through assessment that the consumer requires a level of care they do not offer, has clinical needs best served by another agency, or is unable to provide timely access to care the Contractor is responsible to coordinate and facilitate care at another agency. They will Consent and Refer the client's profile, the County approved assessment and a miscellaneous note containing the authorization request to the appropriate care advocate (OptumHealth, DBHS UM or IGS) and the agency recommended to provide the treatment services. The Contractor will select "yes" in the actual miscellaneous note when asked if you want to release the note. Once the required information is released, the Contractor will contact the care advocate to complete the authorization by phone. The assessing Contractor will coordinate the placement of consumers they cannot serve. They will provide the name of agency recommended to provide the treatment services and will verify that coordination with that agency, including agreement to provide care to the consumer, has occurred.

4. Any assessment billed to either OptumHealth or DBHS will include a Consent and Refer in UWITS to OptumHealth or DBHS as outlined above, even when the results indicate the consumer would benefit from a 0.5 ASAM early intervention, no treatment, or another treatment type (e.g., mental health only services).

The following information is considered in the prospective review and must be included in the information Consented and Referred into OptumHealth, DBHS UM and/or IGS in UWITS:

- Consumer name, UWITS identification number, population, and ASAM Level of Care;
- Funding source of the consumer (Medicaid, County Base funded, or other fund code);
- Agency and facility requesting services for proposed treatment;
- Precipitating event/reason for treatment admission;
- DSM IV-TR diagnosis;

- Completion of ASAM in UWITS Admission with narrative defining the strengths/assets and barriers/needs, dimensional ratings of risk, dimensional recommendations for level of care, and overall recommendations for treatment;
- Comprehensive Assessment in ASAM format that includes treatment history related to substance use and mental health, substance use history, information to support any diagnosis, social supports, medical history, current medications, psychosocial situation, and other relevant information that helps define the strengths and needs of the consumer;
- What client would like to see happen in terms of treatment and proposed services**;** and
- Proposed treatment plan or plan for services, which will include discharge criteria, discharge plan and expected length of stay (ELOS).

OptumHealth, DBHS UM or IGS will determine and provide notice of authorization as expeditiously as the consumer's condition requires, but no later than 14 calendar days from the receipt of all information required in the request. Receipt of all vital information and anticipation of admission date by consumer will expedite this process. OptumHealth, DBHS UM or IGS will give priority to requests that require immediate attention, such as federally prioritized clients to include pregnant females and injecting drug users. The Contractor will be notified of approved admission orally and/or electronically.

Concurrent Review

The concurrent review process involves evaluating continued medical necessity and timeliness of the plan of care from the time of assessment, admission and services provided through discharge. Concurrent reviews are mandatory, requiring continued authorization for the following ASAM levels of care: III.5, III.3, III.1, II.5 and II.1. The review periods are as outlined:

- III.5 level of care is reviewed every 15 calendar days
- III.3 level of care is reviewed every 15 calendar days
- III.1 level of care is reviewed every 30 calendar days
- II.5 levels of care is reviewed every 30 calendar days
- II.1 level of care is reviewed every 60 calendar days

Subsequent reviews will follow this same review period through to transfer, discharge or a determination that the consumer is no longer eligible. The agency will be denied payment for services provided beyond the established review periods without having requested and received authorization. Receipt of all vital information in a timely manner will expedite this process.

The following information is considered in the concurrent process and must be included in the information Consented and Referred to the OptumHealth, DBHS UM or IGS care advocate in UWITS:

- Consumer name, UWITS identification number, population, and ASAM Level of Care;
- Date of Admission;
- Funding Source (i.e. base, fund code, Medicaid);
- Updated employment, insurance, and current income status;
- Current ASAM Level of Care;
- What client would like to see happen in terms of treatment and proposed services;
- Current ASAM treatment plan;
- ASAM narrative in the encounter attached to the treatment plan that reviews the progress towards established treatment goals, the appropriateness of services being provided, updates strengths and barriers in each ASAM dimension, and provides any other relevant information that helps to define medical necessity; and
- Discharge criteria, discharge plan, and ELOS.

OptumHealth, DBHS UM and IGS will determine and provide notice of concurrent authorization as expeditiously as possible, but within 2 business days from the receipt of all information required in the request. The Contractor will be notified of authorization orally and/or electronically.

Retrospective Review

The retrospective review process involves a post evaluation of services on a case-by-case or aggregate basis after the services have been provided. A retrospective review may be initiated if utilization issues are identified. If this occurs the Contractor's Quality Assurance/Performance Improvement Manager will be notified. This notification provides the Contractor the opportunity to supply additional information to support any billings that were submitted for payment. The same criteria used for prospective and concurrent reviews will be utilized to determine medical necessity.

Disclaimer

If any part of this policy is found to be in conflict with Medicaid regulations then the Medicaid regulations will govern the procedures that need to be followed.

Authorization for services does not guarantee claim payment, which may be contingent upon the consumer's continued eligibility or other conditions as outlined in the contract. Also, failure to participate in a scheduled concurrent review on the scheduled date could result in denial of additional services or may lead to payback of services.

COORDINATION OF BENEFITS:

We recognize that consumers frequently move between funding sources. OptumHealth, DBHS UM and IGS will make every effort to assist the Contractor through collaborative efforts when the consumer's benefits or payer changes.

APPEAL PROCESS:

Appeal Process

An appeal is a request for review by DBHS QA of an action taken by OptumHealth, DBHS UM or IGS. An appeal may be made by a consumer or a consumer's authorized representative (including a Provider who has been authorized in writing by the consumer to serve as the consumer's authorized representative). Providers acting on behalf of a consumer must include a copy of the written consent. Review of an action or authorization of requested services may include the type or level of service, the reduction, suspension, or termination of a previously authorized service, the denial, in whole or in part, of payment for a service, or the failure to provide services or a determinations in a timely manner constitutes and action.

If the appeal is regarding a denial that is based on lack of medical necessity or involves clinical issues, the title and credentials of the individual(s) who made the decision on the appeal need to demonstrate that they are individuals who:

1. were not involved in any previous level of review or decision-making and

2. are health care professionals who have the appropriate clinical expertise, as determined by DBHS, in treating the consumer's condition or disease.

Requesting a Consumer Appeal

Appeals must be requested within 30 calendar days from the date of the Notice of Action, which will include an appeal form and an explanation of the appeal process.

An appeal may be submitted to DBHS QA staff either orally or in writing. An oral appeal must be followed by a written confirmation of the appeal, signed by the consumer or consumer representative, within 5 business days of the oral appeal unless the consumer requests an expedited resolution to the appeal. An oral request for an expedited resolution does not require a follow-up written request. Provider acting on behalf of the consumer and/or the DBHS QA staff will assist consumers as needed to file the written appeal.

The DBHS QA staff will acknowledge receipt of the appeal either orally or in writing and explain to the consumer the process that will be followed to resolve the appeal.

If the action being appealed is to terminate, suspend or reduce a *previously authorized* course of treatment, the covered services were ordered by an authorized care advocate and the period covered by the original authorization has not expired, and the consumer wants benefits to continue during the appeal, then the consumer must file the appeal on or before the later of the following:

- Within ten (10) days of the mailing of the Notice of Action; or
- The intended effective date of the proposed action.

Appeal Timeframes for County Resolution

There are two categories of appeals, below outlines timeframes for resolving each type.

Non-Expedited: The DBHS QA staff will resolve a non-expedited appeal, and provide notice to the affected parties no later than fifteen (15) calendar days from the day DBHS QA receives the appeal.

Expedited: The DBHS QA staff will resolve an expedited appeal and provide notice to the affected parties no later than three (3) business days after DBHS QA receives the expedited appeal request. An expedited appeal may only be filed when DBHS QA determines that the time for a standard resolution could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function.

The DBHS QA may extend the time frame for making a decision on an appeal by up to fourteen (14) additional calendar days if the consumer requests an extension or there is a need for additional information and the extension is in the consumer's interest. The DBHS QA staff will notify the consumer in writing of any extension initiated by them.

If DBHS QA does not resolve an appeal within the required time frame, this constitutes an action. The DBHS QA staff will give the consumer a Notice of Action letter at the time DBHS QA staff determines the required time frame will not be met. DBHS QA will provide care advocate with a copy of the Notice of Action. The consumer does not need to go through DBHS QA appeal process again, instead they may now request a State fair hearing when Medicaid eligible

An expedited appeal may not be requested for a service that has already been rendered. If the consumer or consumer's provider requests expedited handling of the appeal and DBHS QA denies the request, DBHS QA will:

- Transfer the appeal to the non-expedited or standard time frame of no longer than 15 calendar days from the day the DBHS QA receives the appeal, with a possible 14-calendar day extension for resolving the appeal and providing Notice of Appeal Resolution to the affected parties;

- Make reasonable effort to give the consumer prompt oral notice of the denial; and

- Mail written notice within two (2) calendar days explaining the denial, specifying the standard time frame that will be followed, and informing the affected parties that the consumer may file a grievance regarding this denial of expedited resolution of the appeal.

Consumer Fair Hearings

Only Medicaid recipients have the right to request a fair hearing with the Utah Department of Health regarding an action taken by OptumHealth. A fair hearing may be pursued by the consumer, an authorized representative, or a provider acting on behalf of a consumer has the right to pursue a fair hearing.

Consumers are notified of their rights and timelines related to a fair hearing by the DBHS QA in accordance with Medicaid requirements. A fair hearing may be requested when appeal processes have been exhausted and the decision was not wholly in favor of the consumer or when the DBHS QA was unable to make a decision on the appeal within the require time frame.

A fair hearing must be requested within thirty (30) calendar days from the date of the DBHS QA's Notice of Appeal Resolution. In the event that the consumer wants to continue benefits pending the outcome of a fair hearing, when a *previously authorized* course of treatment has been terminated, suspended or reduced, the services were ordered by an authorized provider, and the original period covered by the original authorization has not expired, the request for a fair hearing and continuation of benefits must be submitted within ten (10) calendar days after the County mails the Notice of Appeal Resolution.

The Utah Department of Health will reach its decision within ninety (90) calendar days from the date the consumer filed the appeal with the County, not including the days the consumer takes to file the request for fair hearing. In the case of a fair hearing request that meets criteria for the expedited appeal process but was not resolved within the County's expedited appeals time frame or was not resolved wholly in favor of the consumer, the Utah Department of Health will reach its decision within three (3) business days from the date it receives from OptumHealth and the County all needed information, including information from the consumer's medical record.

The Utah Department of Health will notify the consumer in writing of the fair hearing decision and any appeal rights as provided by State and Federal laws and rules.

OptumHealth or the County will assist consumers with required forms as needed to file the request for a fair hearing.

Appeals can be filed by:

Phone: 801-468-2009 **Fax**: (801) 468-2006

Mail: Salt Lake County Division of Behavioral Health Services

Attn: Mental Health Quality Assurance Manager

2001 South Street S2300

Salt Lake City, UT 84190-3050

TTY: Dial 711 (Relay Utah), provide the operator with the County number you are calling