

1.0 Introduction

Alameda County Behavioral Health Care Services (ACBHCS) includes a Utilization Management (UM) Program and Behavioral Health Managed Care Plan (MCP). They are dedicated to delivering cost effective, quality health care to all plan members and beneficiaries in Alameda County.

2.0 Utilization Management Program Description

The Alameda County Behavioral Care's Utilization Management Program includes oversight of behavioral health care services from a utilization perspective, including coordinated review assessment performed to determine the medical necessity and appropriateness of behavioral health care services (UR). The ACBHCS UM Program encompasses inpatient and specialty mental health care services rendered to all Alameda County Medi-Cal beneficiaries, to members of other health plans contracting with ACBHCS to provide services, and all other services provided directly by ACBHCS or indirectly through contractual agreements with ACBHCS. A Behavioral Health Managed Care Plan (MCP), specifically addressing behavioral health care delivery and reimbursement, operates in conjunction with the ACBHCS UM program.

Functions: The UM Program consists of the following components:

- Payment authorization through Prospective Review
- Payment authorization through Concurrent Review
- Monitoring and data collection through Retrospective Review
- Payment authorization through Retrospective Pre-payment Review
- Case-specific Utilization Management
- Coordination of units impacting utilization
- Maintenance of program direction
- Maintenance and generation of policy and procedure
- Maintenance of resource allocation based on performance

Organization and Composition: The UM Committee (UMC) is one of two committees reporting directly to the Quality Improvement Committee (QIC). The UMC responsibilities are designed to determine the extent to which care delivered to Alameda County beneficiaries meets the goals and objectives of the overall UM program. UMC membership includes:

- UM Physician and additional ACBHCS physicians
- Office of Management Services representative
- Designated UM and QA staff
- Representatives from other ACBHCS communities and programs that affect utilization and access to services.

3.0 Goals and Objectives

The UM Program goals and objectives are designed to ensure timely access to appropriate quality

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care. Evaluation of the UM program will be based on the goals and objectives and the criteria to measure improvement that are specified in the following tables:

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ACBHCS - UTILIZATION MANAGEMENT PROGRAM GOALS	
Goals	Criteria That May Reflect/Measure Improvement
1. Determine areas of overutilization, underutilization, and inefficient utilization of resources.	Pre-established thresholds for service utilization.
2. Ensure that providers comply with ACBHCS's UM policies and procedures.	Authorization reports and individual case reviews.
3. Determine if behavioral health services are delayed or withheld.	UM activity and system utilization reports, Consumer Assistance reports, appeal data, satisfaction surveys and reports.
4. Determine the appropriateness, availability, access, timeliness, continuity, and efficiency of behavioral health services.	QM focused review, department audit function, UM reports.
5. Ensure utilization of services meets standards of good behavioral health care practice.	UM denial reports, including denial rates, peer review reports.
ACBHCS - UTILIZATION MANAGEMENT PROGRAM OBJECTIVES	
Objectives	Criteria That May Reflect/Measure Improvement
1. Provide the Quality Improvement Committee (QIC) with information, analysis, and recommendations and ensure inclusion of all beneficiaries in the Quality Management process.	Focused review and departmental audit reports, QIC minutes.
2. Evaluate patterns of care and appropriate use of available resources and services.	UM and claims reports.
3. Determine utilization practice patterns and trends.	Provider profiles, including specialty profiles, and claims reports.
4. Ensure that identified problem areas are reviewed by the UM Committee.	UM Committee minutes.
5. Monitor billing practices, accuracy of information provided and review determinations, including consistency of authorization process.	Billing, caseload, QA, service reports, appeals, inter rater reliability tools.
6. Educate ACBHCS's staff and provider network on the components of the UM program and on UM program results.	UMC minutes, billing, caseload, QA, service reports, provider manual.
7. Provide UM Program oversight through the UM Committee.	UMC minutes and UM reports.
8. Provide a mechanism for self-evaluation of UM program effectiveness and efficiency;	UM activity and system utilization reports.

Confidentiality

The UM Program and the UMC will maintain the confidentiality of all beneficiary records at all times. The UM Program will operate according to the ACBHCS-UM Program confidentiality policies which consider all UM activities including findings of UM studies confidential. All review activities requiring clinical records will be stored in locked files. Access to files is limited to specific staff. Staff access to on-line information is limited to pre-established screens and functions requiring a password.

5.0 Utilization Management Committee

The Utilization Management Committee is responsible to the ACBHCS- Medical Director.

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5.1 Authority and Responsibility

The UM Committee responsibilities are designed to determine the extent to which care delivered to Alameda County beneficiaries meets the goals and objectives of the overall UM program. The responsibilities of the UM Committee is to:

- Develop, recommend, and refine UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, reliability of indirect clinical information. Involve appropriate, actively practicing practitioners as well as other behavioral health plans in the development of criteria for UM decisions and the development and review of procedures for applying the criteria. Review criteria and determine need for update at time of annual review of UM Plan.
- Report to the QIC regarding program effectiveness
- Promote the establishment of mechanisms to evaluate over- and under-utilization of behavioral health care services
- Provide input to QIC and units under QIC oversight and approve UM policies and procedures.
- Monitor and provide peer review of UM activities through the evaluation of utilization reporting, appeal/reconsideration requests, and provider profiling. In the case of payment authorization decisions performed by an authorization unit, monitoring will include, at least on a biannual basis, gathering of information from beneficiaries, practitioners, and providers regarding their satisfaction with the UM process. Identified sources of dissatisfaction will be addressed by the UMC. '
- Provide oversight of UM activities that have been delegated by the ACBHCS. This will include maintenance of a written mutually agreed upon document describing responsibilities of the UMC and the delegated entity, the delegated activities, the frequency of reporting to the UMC, the process by which the UMC evaluates the delegated entity's performance, and the remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations. The UMC will maintain documentation that verifies that the UMC evaluates the delegated entity's capacity to perform the delegated activities prior to delegation, that the UMC has approved the entity's UM program annually, that the UMC annually evaluates whether the delegated activities are being conducted in accordance with regulatory and ACBHCS standards, and that the UMC has prioritized and addressed with the delegated entity opportunities identified for improvement.
- Recommend to administration changes in practice patterns to conform to standard practice regarding UM issues.
- Recommend sanctions for program noncompliance to the QIC.

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- Provide recommendations to Quality Management following completion of peer reviews.

- Review annually the UM Program, make recommendations to the QIC for revisions to the program as indicated. This review includes review of the consistency of the authorization process.

5.3 Committee Membership

The ACBHCS-'s UM Committee will be comprised of the UM Physician as Chairperson, additional ACBHCS- physicians, the Director of Management Services, designated UM and QA staff, representatives from other ACBHCS- committees and programs that impact utilization and access to services. Membership may include the Directors of Adult and Children's Services, Directors of ACCESS and Authorization, Data Support staff, Outpatient and Inpatient Program Administrators, Director of Finance and staff, including Contracts, and Provider Relations. Designees with appropriate background and, if indicated, licensure, may attend for a member. Term of membership is indefinite. Only practitioners, including licensed or "waivered/registered" mental health staff shall have the right to vote on medical issues. A quorum consists of three practitioners. When issues concerning a specific health plan are reviewed, representatives of that Health Plan will be allowed to attend the portion of the meeting concerning that Health Plan. The time members spend in UM activities varies with the responsibilities of the member within the ACBHCS organization and the current focus of activity of the UMC. Members who are or were involved in the care of a beneficiary or who have a financial interest in a case may not participate in review of that case.

5.4 Meeting Frequency

The UM Committee meets at least eight times per year or more frequently as required to remain current with UM program activities. Subcommittees may meet in addition to the UM Committee to carry out specific tasks.

5.5 Records Kept: Utilization Management Committee Minutes

The UMC minutes will reflect the following for each committee meeting:

- Utilization issue
- Conclusion
- Recommendations
- Corrective action
- Follow-up for each issue
- An "old business" item that lists outstanding issues indicating: the initial date the issue was brought to UMC, a short title for the issue, the action required, the person responsible for implementation, the due date for completion, the current status.

The agenda for the UMC meeting will be distributed to members before each meeting whenever possible. Within confidentiality constraints, minutes will be distributed with the agenda. Within confidentiality constraints, reports are distributed at the meeting.

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6.0 Utilization Management Program Components

- Payment Authorization for acute psychiatric hospital services occurs through a Point of Authorization. For specialty mental health services, programs will be assigned one of three authorization mechanisms: a Point of Authorization, an on-site committee, or a centralized committee.
- Staff who makes payment authorization decisions concerning mental health services will be licensed or "waivered/registered" mental health staff.
- Relevant clinical information is obtained and used for authorization decisions. As appropriate to the level of care and intent of service, discharge planning will be reviewed and required on admission to each service. Statewide medical necessity criteria and other criteria unique to each payer source are used to make authorization decisions. If needed, board-certified physicians from appropriate specialty areas are available to assist in making medical necessity determinations.
- The ACBHCS provides medical necessity criteria to its practitioners, providers, consumers, family members and others upon request.
- Behavioral Health authorization decisions are made in accordance with regulatory and payer source timeliness standards for authorization of services for urgent conditions.
- A second opinion from a specialist in the mental health field is granted when requested by a member or a provider.

- The Behavioral Health Managed Care Plan will monitor, through the UMC, the authorization process to ensure it meets the standards for authorization decision making and will take action to improve performance if it does not meet standards.
- Written medical care criteria, specific to the benefits of the member plans and payer sources, will be made available to the UMC members and to individuals performing authorization functions through policy and UMC communications.
- Information about the beneficiary grievance and fair hearing processes will be included in all denial notifications sent to beneficiaries.
- The UMC identifies over and under utilization. Data is gathered at regular intervals and appropriate interventions are initiated. These interventions address identified barriers or a specific circumstance. The interventions are implemented in a timely manner and include standards and thresholds. The interventions address the organization as a whole and address each product line and practice-specific findings. Utilization issues are identified from a set of standard reports and from special reports developed in response to areas of concern identified by committee members. The UMC maintains a tracking tool to schedule reports for monitoring and takes action when a threshold is exceeded. The UMC goals and objectives as defined in this plan serve as a guide in identifying opportunities for improvement and in delineating the goals to achieve through intervention.
- The UMC may oversee or directly conduct Medical Care Evaluation Studies. Studies may include evaluation of admissions, over and underutilization, length of stay, scheduling and use of resources, ancillary and professional services, reports provided by other entities, high-cost services or utilization patterns. The UMC minutes will indicate that analysis of the medical care studies has occurred and that actions have been taken based on these studies that promote effective, efficient, quality care.

6.1 Prospective Review

Description

Prospective Review occurs prior to delivery of requested health care services to determine medical appropriateness and/or level of care. Information is obtained through verbal and written communication that may include information from the medical record. In the case of behavioral health care services, prior payment authorization requirements may include:

- All inpatient services, except the first twenty-four hours following any emergency admission
- All elective admissions to an inpatient service
- Additional diagnoses/procedures identified by the MHP
- All specialty services

- Prospective review payment requests will be completed within two calendar weeks of the postmark or FAX date of the authorization unit or committee's receipt of the request and relevant information. Prior authorization will be valid for one calendar week in advance. Inpatient admission review will be initiated within one working day of notification of admission. All authorizations are subject to verification through the prepayment review function.

- Adverse decisions' will be reviewed and approved by an ACBHCS Physician. Appeals may be made through the ACBHCS Appeals/Reconsideration process. Initial requests for treatment authorization and appeals not submitted within specified timelines can be denied. If a request is denied prior to hospitalization, ACBHCS will notify the beneficiary within ten calendar days if requested by the attending physician.

- ACBHCS will address access for planned admissions to contract facilities.

Process

The prospective review process consists of the following steps:

- Provider provides a written prior authorization request by mail, FAX, or telephone to ACBHCS Behavioral Health Managed Care Plan's authorization unit or committee.

- The UM Reviewer obtains additional information if needed and evaluates the request.

- Within two calendar weeks of receipt, the payment request is either approved or has been reviewed by a UM Physician and has been denied through second-level review.

- The provider or individual initiating the payment request is notified by FAX/telephone of the determination. A notification is sent either by FAX or by mail. If payment is not authorized, the notification specifies the rationale for the denial and the appeal/reconsideration rights and procedures.

- The provider is responsible for coordinating internal communication between its clinicians, utilization staff, and discharge planning staff and will identify a responsible department or individuals within its organization who will be able to communicate with the ACBHCS

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UM staff concerning all aspects of authorization. The UM Reviewer will evaluate medical necessity and discharge plans -when providing consultation and when determining payment authorization. Potential Quality of Care, Risk Management, and Case Management issues, as defined by the UMC, are forwarded to the QIC.

6.2 Concurrent Review

Description

Concurrent review is a review process to determine a beneficiary's need for continued treatment.

Critical underutilization and provider or system inefficiency, as defined by the UMC, are identified and forwarded to the UMC and QIC.

Concurrent review, but not necessarily concurrent payment authorization, will be initiated within one working day of hospital admission notification or within one working day of the expiration of any prior authorization for hospital services.

A payment request for continued stay services may be made during a hospital stay or course of treatment for specialty mental health or Alcohol and other Drugs services that have been delivered or for services that may be delivered. The request may be received by the ACBHCS authorization unit or committee within two calendar weeks of discharge.

Requests for payment will be processed within two calendar weeks of the postmark or FAX date of the Managed Care Plan's receipt of the request and relevant information. All authorizations are subject to verification through the prepayment review function.

Adverse decisions will be reviewed and approved by an AGBHCS UM Physician. Appeals may be made through the ACBHCS Appeals/Reconsideration process. Requests for treatment authorization and appeals not submitted within specified timelines can be denied.

Process

The concurrent review process consists of the following steps: Acute Psychiatric Inpatient Services:

- The UM Reviewer is notified of a beneficiary's admission via the prospective review process (elective admissions) or the provider (emergency admissions.)
- The UM Reviewer obtains additional information as necessary and reviews the length of stay, either on site or by telephone, for medical appropriateness.

All services:

- Following review, a length of stay, number of visits or services, or treatment period may be approved and payment authorized or, the case may be referred to a UM Physician for second-level review, or the Reviewer may provide consultation and defer an authorization decision. Additional concurrent reviews may occur during the course of treatment, based on expiration of prior authorization, recommended length of stay, or identified need for additional consultation.

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- If there is an adverse decision, the hospital/provider will be advised of the adverse decision within two working days of the decision. The notification will be in writing and will specify the rationale for the denial, the non-covered dates and the appeal and reconsideration rights and procedures. Within one working day of notification, the hospital/provider will be required to provide a written notice to the beneficiary, if still hospitalized, and to the attending physician, and will obtain a signature from the beneficiary indicating receipt of the notice. If the beneficiary is no longer hospitalized or receiving services from the provider, the notice of non-coverage will be processed and delivered through the fiscal intermediary for Medi-Cal beneficiaries and through the designated agent for other payer sources.

- In all cases, authorization decisions are subject to verification of information and pre-payment review. A final payment authorization decision is made- when the payment request is received and the provider is then notified by FAX or mail within two calendar weeks of the determination.

- The provider is responsible for coordinating internal communication between its clinicians, utilization staff, and discharge planning staff and will identify a responsible department or individuals within its organization who will be able to communicate with the ACBHCS MHP UM staff concerning all aspects of authorization. The UM Reviewer will evaluate medical necessity and discharge plans when providing consultation and when determining payment authorization. Potential Quality of Care, Risk Management, and Case Management issues, as defined by the UMC, are forwarded to the QIC.

6.3 Retrospective Pre-Payment Review

Description

Pre-payment Review is conducted for rendered health care services to verify information provided during prospective and concurrent review and to review services that did not receive prior authorization or concurrent review. The review serves as the final step in authorization for payment of services and to monitor the following:

- Medical appropriateness of health care services
- Quality of care
- Benefit determination

Process

The pre-payment review process consists of the following steps:

- ACBHCS MHP authorization unit or committee is notified that services have been rendered to a beneficiary, either directly by the provider or through the claims process.
- The UM Reviewer obtains additional information as needed and reviews the claim for medical appropriateness.
- Following review, the claim is either approved for reimbursement or is referred to the UM Physician for a second-level review.
- When a payment authorization determination is made, the provider will be notified by FAX or mail. For denied inpatient stays, a notification will be issued to the designated hospital administrator within two working days of the decision. The notification will specify the rationale for the decision, the non-covered dates and the appeal and reconsideration rights and procedures. The hospital/provider will be required to provide a copy of the notice to the beneficiary, if still hospitalized, and to the attending physician, and to concerned parties, and will obtain a signature from the beneficiary indicating receipt of the notice. If the beneficiary is no longer hospitalized or receiving services, the notice of non-coverage will be processed and delivered through the fiscal intermediary.
- Potential Quality of Care, Risk Management, and Case Management issues, as defined by the UMC, are forwarded to the QIC.

7.0 Case Management

The UM Program and case management providers work closely together to provide timely authorization for payment of services, to create access to services, and to intervene early in cases that are high-risk or complex. While there is some overlap in function, the Authorization Unit acts to identify to case management providers those cases that are high-risk or complex or are in need of special assistance to minimize use of hospital and other costly services. Designated case management staff may provide short-term payment authorization for inpatient care and will provide information and confer with UM staff concerning these authorization decisions.

8.0 Reconsideration /Appeals

8.1 Description

Reconsideration/appeals are a process for the re-review of a denial of payment for behavioral health care services.

All written non-certification notices will include instructions to the beneficiary and provider as to the formal reconsideration/appeals process.

All reconsideration/appeals requests will be completed within two calendar months from the date of receipt of the request.

Any change in payment authorization as a result of an appeal to ACBHCS- or to the State will require that the provider submit a revised request for payment. The ACBHCS- authorization unit will process revised requests within two calendar weeks of receipt of the request.

8.2 Process

The reconsideration/appeals process consists of the following steps:

- ACBHCS- UMC receives a written request for reconsideration/appeal. The UMC will consider . written appeals submitted within three calendar months of the provider's receipt of notification of the adverse decision. The date of receipt for the UMC and the provider is either the FAX date or the postmark.
- ACBHCS- UMC will obtain additional information as needed.
- A UM Physician reviews all available information and makes a determination to uphold, modify, or reverse the original denial.
- The appealing party receives a notification of the determination within two calendar months of the UMC's receipt of the request. If any of the services that were originally denied payment are still denied, other available rights/procedures for appeal, including appeal to the State, will be included in the notification letter.

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9.0 Admission and Length of Stay Criteria

All payment authorization decisions will be based on knowledge of regulations and guidelines defining medical necessity, the clinical experience of the reviewer, and the clinical information and recommendations of the individual requesting authorization.

9.1 Review Interval

Length of stay/payment authorization will not exceed seven days per inpatient review. Specialty service length of stay /payment authorization is determined by several factors, including type of service, client history, age, current presentation, and clinical considerations

9.2 Focused Review

Cases remaining in the hospital for sixty days will be reviewed by a UM Physician. Other cases, as defined by the UMC, will be subject to focused review.

10.0 Acute Administrative Days

Acute administrative days will be authorized by the ACBHCS- authorization unit when a Medical beneficiary's stay in an acute inpatient facility must be continued beyond the beneficiary's need for acute care due to the lack of placement options at appropriate, non-acute treatment facilities.

The acute inpatient facility is responsible for contacting appropriate facilities within a sixty-mile radius of, at UMC discretion, a reasonable distance, at least "once each" five working days until a beneficiary is placed or no longer requires that level of care. These contacts must be documented by a brief description of the level of care status of the beneficiary, the status of the placement option, and the signature of the person making the contacts. The UM Inpatient Reviewer will monitor the beneficiary's chart on a weekly basis to determine if the beneficiary's status has changed.

In most cases, the UM Inpatient Reviewer and hospital will define in general terms the appropriate facilities to be contacted for each beneficiary. The UM Inpatient Reviewers may waive the requirement of five contacts per week if there are less than five appropriate, non-acute treatment facilities available as placement options for the beneficiary. The hospital will provide a copy of the beneficiary's chart for review on a weekly basis.

10.1 Criteria

Payment for Acute Administrative days will be authorized when:

- During the course of hospitalization, a beneficiary previously has met criteria for acute inpatient hospital reimbursement.
- Review of the medical record indicates that the beneficiary's medical and nursing care needs and amount and frequency of services are at a level of care that requires placement in a non-acute treatment facility.
 - or Review of the medical record indicates that the acute inpatient facility is providing a higher level of care than the beneficiary requires but that the level of care available in the

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community is insufficient to meet the beneficiary's care needs.

- The medical record indicates that the acute inpatient facility initiated placement efforts prior to the termination of acute care coverage and is documenting efforts and contacts at the required weekly frequency and within the required mileage radius or reasonable distance.
- The medical record indicates at least on a weekly basis an- assessment of level of care that supports placement in a non-acute treatment facility.

11.0 Payment for Services Provided By a Non-Contract Hospital/ Stable for Transport Guidelines

11.1 Definitions

Stable for transport means that the acute care patient is able to reasonably sustain a transport in an Emergency Medical Technician I staffed ambulance, with no expected increase in morbidity or mortality.

11.2 Guidelines

Emergency admissions, whether to contract or non-contract hospitals, are exempt from prior authorization requirements. Contract hospitals and hospitals outside the ACBHCS- contracting network of providers will be reimbursed for medically necessary inpatient services provided to beneficiaries when the beneficiary meets the State regulations and guidelines defining medical necessity and, as a result of a mental disorder, the beneficiary is a danger to self or others or is immediately unable to provide for, or utilize, food, clothing, or shelter.

To receive payment for an emergency admission, the provider must notify the authorization unit within twenty-four hours of admission and must submit documentation supporting medical necessity, the existence of an emergency condition and continuance of the emergency condition for each day of service for which reimbursement is requested. If the provider has indicated that the patient is not stable for transport, documentation supporting this condition must also be submitted.

Once the ACBHCS- authorization unit determines that a patient was appropriately admitted to a non-contracting hospital on an emergency basis, the UM Inpatient Reviewer will authorize payment for one day of acute hospital stay. Authorization of any additional days of stay at a non-contracting hospital will be granted if, based on reasonable clinical judgment, the beneficiary's condition is not stable for transport, or if the UM Inpatient Reviewer determines that continued stay in the non-contracting hospital is both clinically appropriate and the most efficient use of resources.

At the discretion of the ACB.HCS- authorization unit, a non-contract hospital may also receive payment for a planned admission when an acute hospital service or treatment is not available within the network of contract hospitals and is available at the non-contract hospital.