1.0 Introduction

Alameda County Behavioral Health Care Services (ACBHCS) is dedicated to delivering accessible, cost effective, quality behavioral health care to Medi-Cal beneficiaries and residents of Alameda County. These continuum of care services include Specialty Mental Health services (SMHS) and Substance Use Disorder (SUD) treatment services.

2.0 Utilization Management Program Description

The ACBHCS Utilization Management (UM) Program is a program that includes oversight of behavioral health care services from a utilization perspective, including coordinated review assessment performed to determine the medical necessity, appropriateness and efficiency of behavioral health care services. The ACBHCS UM Program encompass both SMHS and SUD treatment services rendered to Alameda County Medi-Cal beneficiaries and residents, provided either directly by ACBHCS or indirectly through contractual agreements with ACBHCS. A Mental Health Plan (MHP), specifically addressing specialty mental health care delivery and reimbursement, operates in conjunction with the ACBHCS UM Program. An Intergovernmental Agreement (IA), specifically addressing substance use disorder treatment service delivery and reimbursement in the Drug Medi-Cal-Organized Delivery System (DMC-ODS), operates in conjunction with the ACBHCS UM Program.

The UM Program consists of the following components:

- Prospective Review and Prior Authorization *(*Please note: Prior Authorizations are for service and are not a guarantee of payment; are subject to retrospective pre-payment review)*
- Concurrent Review and authorization *(*Please note: Concurrent authorizations are consultative and are not a guarantee of payment; are subject to retrospective pre-payment review)*
- Payment authorization through Retrospective Pre-payment Review
- Monitoring and data collection through Retrospective 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

3.0 UM Program Authority and Responsibility

Alameda County Behavioral Health Care Services is responsible for the UM Program.

The Quality Management Program Director has the responsibility for oversight of the UM activities. The UM Physician serves as the clinical professional responsible for

monitoring UM activities. The UM Division Director directs, coordinates and supervises ACBHCS' effective and efficient use of resources and ensures that optimal reimbursement from Medi-Cal, Medicare, and other payers occurs; serves as the Chairperson of the Utilization Management Committee (UMC), a subcommittee of the Quality Improvement Committee (QIC). The UM Supervisor supervises Clinical Review Specialists, coordinates day-to-day functions, ensures appropriate staff coverage, and assists in UM administrative functions and related work as required.

Behavioral health care services (BHCS) authorizations are assigned to one of three authorization mechanisms: a Point of Authorization (POA), an on-site committee, or a centralized committee. Staff who render authorization decisions are all licensed or "waivered/registered" clinical staff. ACBHCS UM staff who render authorization decisions are licensed and American Society of Addiction Medicine (ASAM) trained clinicians. Relevant clinical documentation is obtained and used for authorization decisions, in accordance with Statewide medical necessity criteria. ACBHCS makes available medical necessity criteria to its practitioners, providers, beneficiaries, family members and others. Authorization decisions are made in accordance with Federal, State and contractual agreement timeliness standards for authorization. The MHP 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. Information about the beneficiary grievance and fair hearing processes are included in all denial notifications sent to beneficiaries.

ACBHCS UM policies and procedures are in accordance with pertinent Federal and State regulations, laws, and statutes; and contractual agreements:

- California Health and Safety Code (HSC)
- California Welfare and Institutions Code (WIC)
- Title 42, Code of Federal Regulations (CFR): Public Health
- Title 9, California Code of Regulations (CCR): Rehabilitative and Developmental Services
- Title 22, California Code of Regulations (CCR): Drug Medi-Cal Substance Use Disorder Services
- DMC-ODS Intergovernmental Agreement (IA)
- Mental Health Plan (MHP)

3.1 UM Program Responsibility: SMHS

Payment authorization for acute psychiatric hospital services occurs through a Point of Authorization (POA). ACBHCS UM is the designated POA. Non-hospital SMHS programs are assigned one of the aforementioned three authorization mechanisms. ACBHCS UM is the POA for Day Treatment services (i.e. Day Rehabilitation and Day Treatment Intensive), authorization requests for children with foster care, Adoption Assistance Program (AAP), or Kin-GAP aid codes living outside of his/her county of origin, ACBHCS MHP Network Fee-for-Service (FFS) outpatient providers, and other appointed ACBHCS or contracted services. ACBHCS is also the POA for concurrent review of Adult Residential Treatment (ART) and Crisis Residential Treatment (CRT) services.

3.2 UM Program Responsibility: SUD Treatment Services

ACBHCS UM is the designated Point of Authorization (POA) for SUD Residential Treatment Services. Prior authorization is required for SUD Residential Treatment Services. Authorizations are determined utilizing both Statewide medical necessity criteria and American Society of Addiction Medicine (ASAM) criteria.

4.0 Goals and Objectives

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

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 UM policies and procedures	UM reports and individual case reviews
3. Determine if services are delayed or withheld	UM activity and system utilization reports
4. Determine the appropriateness, availability, access, timeliness, continuity, and efficiency of services.	QM focused review, department audit function, UM reports
5. Ensure utilization of services meet Evidence Based Practices.	UM denial reports, including denial rates, peer review reports, and Quality Log

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 problems areas are reviewed by the UM Committee	UM Committee minutes
5. Monitor billing practices, accuracy of information provided and review determinations	Billing, caseload, QA, service reports
6. Educate ACBHCS staff and provider network on the components of the UM	UMC minutes, billing, caseload, QA, service reports

ACBHCS UTILIZATION MANAGEMENT PROGRAM OBJECTIVES	
Objectives	*Criteria That May Reflect/Measure Improvement*
program and on UM program results.	
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

5.0 Confidentiality

ACBHCS will maintain the confidentiality of all clinical records at all times. The UM Program will operate according to ACBHCS 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 will be limited to specific staff. Staff access to electronic information will be limited to pre-established screens and functions and will require a password.

6.0 Utilization Management Committee

The Utilization Management Committee is responsible to the ACBHCS Quality Management Program Director and to the Quality Improvement Committee.

6.1 UMC 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 are 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, and sanctions for noncompliance with the program.

- 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 requests, and provider profiling. In the case of payment authorization decisions performed by UM, 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 ACBHCS. This will include maintenance of a written mutually agreed upon document describing responsibilities and the delegated entity, the delegated activities, the frequency of reporting to ACBHCS, the process by which ACBHCS evaluates the delegated entity's performance, and the remedies, including revocation of the delegation, available ACBHCS entities if the delegated entity does not fulfill its obligations. The UM Committee will maintain documentation that verifies that ACBHCS evaluates the delegated entity's capacity to perform the delegated activities prior to delegation, that ACBHCS has approved the entity's UM program annually, that ACBHCS annually evaluates whether the delegated activities are being conducted in accordance with Federal, State and ACBHCS standards, and that ACBHCS has prioritized and addressed with the delegated entity those 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.

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

- Review annually the Utilization Management Program, and make recommendations to the QIC for revisions to the program as indicated. This review will include review of the consistency of the authorization process.

6.2 Committee Membership

The ACBHCS UM Committee will be comprised of:

- UM Physician and additional ACBHCS physicians
- Quality Management Program Director or designee
- Designated UM and QA staff
- Representatives from other ACBHCS committees and programs that impact utilization and access to services.

6.3 Meeting Frequency

The UM Committee will meet monthly or more frequently as required to remain current with the activities of the UM program.

6.4 Utilization Management Committee Minutes

The UMC minutes will reflect the following minutes format 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.

7.0 Prospective Review and Prior Authorization

7.1 Description

Prospective Review occurs prior to delivery of requested health care services to determine medical necessity and/or level of care. Information is obtained through verbal and/or written communication, which may include information from the medical record.

Prior authorization is an approval for a covered service that meets medically necessity, prior to services being rendered. Please note: Prior authorization does not guarantee payment. All service authorizations are submit to retrospective pre-payment review, which is review for continued medical necessity, verification of provider and beneficiary continued eligibility status, and that ACBHCS claim submission timeliness standards have been met. Payment may be withheld or reduced if the service rendered was not a covered benefit, deemed medically unnecessary or inappropriate, or claim was untimely.

7.2 Prospective Review and Prior Authorization

Prospective Review and Prior Authorization occur or may occur for the following:

SMHS:

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

SUD:

- Residential Treatment authorization requests (Prior Authorization required)

7.3 Retrospective Pre-Payment Review

SMHS:

- For inpatient hospital services, UM completes payment authorization within five (5) business days upon receipt of the reimbursement request (e.g. Treatment Authorization Request [TAR 18-3]), entire medical record, and all other relevant information necessary to render an authorization determination.

- For prior authorized non-hospital SMHS, a provider is to submit a payment reimbursement request/claim to ACBHCS Billing and Benefits Services (formerly

known as Provider Relations), Claims Department or ACBHCS Network Office; subject to payment review.

- Adverse decisions are made by individuals who have the appropriate clinical expertise in addressing the beneficiary's condition. Inpatient hospital service reimbursement denials are made by a Physician. Appeals may be made through the ACBHCS Appeals Process. Beneficiary initiated First Level Appeals are the responsibility of ACBHCS Quality Assurance (QA). Beneficiary initiated Second Level Appeals, known as State Fair Hearings, are the responsibility of ACBHCS UM. Please note: Providers of inpatient hospital services may appeal to ACBHCS UM any adverse payment decisions. Initial requests for treatment authorization and appeals not submitted within specified timelines may 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.

SUD:

- For prior authorized Residential Treatment Services, a provider is to ensure accurate and timely service entries in the electronic health record (EHR) and Alameda County billing/data system.

- Adverse decisions will be made by UM clinical staff, who are all Licensed Practitioners of the Healing Arts (LPHAs) and ASAM trained. The UM Physician is not required to render adverse decisions. Appeals may be made through the ACBHCS Appeals Process.

7.4 Process

The prospective review process consists of the following steps:

- Provider provides a verbal and/or written pre-authorization or prior authorization request by mail, FAX, telephone, or secure electronic transmission to UM.

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

- For standard authorization requests, an authorization will be rendered within five (5) business days upon receipt date of the request. For expedited authorization requests, an authorization will be rendered no later than seventy-two (72) hours after receipt of the request. EXCEPTION: SUD Residential Treatment authorization determinations will be rendered within twenty-four (24) hours of request receipt.

- The provider or designee is notified by FAX/telephone/secure electronic transmission of the determination. Written notification is either sent by FAX, mail, or secure electronic transmission. If service/ payment is not authorized, the notification specifies the rationale for the denial and the appeal 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 UM staff concerning all aspects of authorization. The UM clinical staff will evaluate medical necessity and discharge/aftercare plans when providing consultation and make recommendations to ensure full and appropriate utilization of County resources. Potential Quality of Care, Risk Management, and Case Management issues, as defined by the UMC, are forwarded to the QIC.

8.0 Concurrent Review of Service and Authorization

8.1 Description

Concurrent review is a review process to determine a beneficiary's need for continued treatment. Concurrent review is conducted for SMHS inpatient hospital services and ART and CRT services.

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

Consultative concurrent review is initiated within one working day of SMHS hospital or residential admission notification. The consultative concurrent review schedule for any other SMHS or SUD treatment services are set forth in contractual agreements and ACBHCS policies and procedures. Please note: All consultative authorizations are subject to retrospective pre-payment review.

A payment request for continued stay services may be made during a hospital or stay or course of treatment for SMHS or SUD treatment services that have been delivered or for services that may be delivered. The request is to be received within five (5) business days after the date of discharge or another contractually agreed upon timeframe.

Payment authorization occurs after completion of retrospective pre-payment review. For SMHS inpatient hospital services, an inpatient facility is to submit to ACBHCS UM a written payment request (e.g. TAR 18-3) within five (5) business days after the beneficiary's date of discharge. UM completes pre-payment review and payment authorization process within five (5) business days upon the date of request receipt. Payment authorization for other SMHS and SUD services are submit to the retrospective pre-payment review through either the ACBHCS Provider Relations, Claims Processing Unit or ACBHCS Network Office.

Adverse decisions for SMHS inpatient hospital services are made by the UM Physician. Adverse decisions for SUD treatment services are made by UM clinical staff who are Licensed Practitioners of the Healing Arts (LPHA) and ASAM trained. Beneficiaries and providers may appeal through the ACBHCS Appeals Process. Requests for treatment authorization and appeals not submitted within specified timelines may be denied.

8.2 Process

The concurrent review process consists of the following steps:

- The UM Reviewer is notified of a beneficiary's receipt of SMHS or SUD treatment services.

- The UM Reviewer obtains clinical and treatment information, either telephonically and/or through clinical documentation, and makes medical necessity determinations and provides disposition/aftercare recommendations to ensure full and appropriate utilization of County resources. (Please Note: Consultative authorizations are not a guarantee of payment; subject to retrospective pre-payment review).

All services:

- Following review, a length of stay, number of visits or services, or treatment period may be approved and given pre-payment authorization or, the case may be referred to a UM Physician for a second-level review, or the UM 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 or recommended length of stay or identified need for additional consultation.

- If there is an adverse decision, the SMHS or SUD 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 or treatment period, and the appeal and reconsideration rights and procedures. Within one working day of notification, the SMHS or SUD provider will be required to provide a written notice to the beneficiary.

- Are subject to retrospective pre-payment review. Medical necessity determinations made during consultation are subject to verification of information and pre-payment review. A final payment authorization decision is made when the written payment request is received from the provider or upon verification of provider completion of all necessary Alameda County billing/data system updates.

- 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 Clinical Review Specialist will evaluate medical necessity and discharge/aftercare plans when providing consultation and make recommendations to ensure full and appropriate utilization of County resources. Potential Quality of Care, Risk Management, and Case Management issues, as defined by the UMC, are forwarded to the QIC.

9.0 Retrospective Review

9.1 Description

Retrospective Review is a data collection and review process conducted after the request for reimbursement for rendered services has been processed. The review is intended to ensure the delivery of cost-efficient, quality health care.

Retrospective reviews will be conducted for the following:

- Focused review of a sample of medical records to assess accuracy of provider information provided through payment requests and other non-medical record communications

- Focused review of a sample of medical records to determine medical necessity, ensure appropriate review decisions, and ensure matching of provider billing information with care/services documented in the medical record.

- Provider profiling to determine utilization trends and provider practice patterns.

- Focused review to determine utilization trends.

- Statistical analysis and interpretation by specialty and beneficiary population.

9.2 Retrospective Authorization Requirements of SMHS

ACBHCS conducts retrospective authorization of SMHS under the following circumstances:

- Retroactive Medi-Cal eligibility determinations
- Inaccuracies in the Medi-Cal Eligibility Data System
- Authorization of services for beneficiaries with other health coverage pending evidence of billing, including dual-eligible beneficiaries
- Beneficiary failure to identify payer

9.3 Process

The retrospective review consists of the following steps:

- Data collection occurs through claims and encounter data submitted to the claims department and UM or committee. It also occurs through focused review studies, interviews, clinical record reviews and other reports.

- Information obtained is analyzed and reported to the UMC to determine corrective action and follow-up.

- Information obtained is reviewed by the UMC for trend and provider practice patterns. This will assist in determining educational needs, corrective action and follow-up, as well as ways to improve the utilization management process.

10.0 Retrospective Pre-Payment Review

10.1 Description

Pre-payment Review is conducted for rendered behavioral health care services to verify accuracy of information provided during prospective and concurrent review and also to

review services that did not receive prospective or concurrent review. The review serves as the final step in authorization for payment of services and to monitor the following:

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

10.2 Process

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

- UM is notified that services have been rendered to a beneficiary.

- The UM Reviewer obtains and reviews supporting documentation and additional information as needed to verify medical necessity.

- Following documentation 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 and beneficiary will be notified by FAX, mail, or secure electronic transmission. For SMHS denied inpatient hospital service, the provider and beneficiary are notified within five (5) business days upon receipt of the reimbursement request. The notification will specify the rationale for the decision, the non-covered dates and the appeal rights and procedures.

- Identification of potential Quality of Care, Risk Management, and Case Management issues, as defined by the UMC, are forwarded to the QIC.

11.0 Case Specific Utilization Management

The UM Program and SMHS and SUD case management providers will work closely to provide timely service and payment authorization, to create access to services, and to intervene early in cases that are high-risk or complex. While there is some overlap in function, UM acts to identify those cases that are high-risk or complex or are in need of special assistance to avoid or shorten SMHS inpatient hospital stays and/or ensure beneficiaries are smoothly and expeditiously transitioned to the appropriate least restrictive treatment setting.

12.0 Appeals

12.1 Description

Appeals is a process for the re-review of a denial of service or payment for health care services.

All written notifications to the provider and beneficiary include instructions on how and the timeliness to file a formal appeals process.

All appeals requests will be completed within sixty (60) calendar days of the date of request receipt.

Any change in payment authorization as a result of an appeal to ACBHCS or the Department of Health Care Services (DHCS) will require that the provider submit a revised request for payment. UM will process revised requests within fourteen (14) calendar days of request receipt.

12.2 SMHS Hospital Appeals Process

The appeals process consists of the following steps:

- UM receives a written appeal request from the hospital. The MHP will consider written appeals submitted within ninety (90) calendar days of the date of provider notification of the adverse decision. The date of provider notification is either the date of FAX, post mark, or e-mail.
- UM obtains 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 sixty (60) calendar days of the date of the appeal receipt. If any of the services that were originally denied payment are upheld, the rights/procedures to appeal to DHCS will be included in the notification letter.

13.0 SMHS Acute Psychiatric Hospital Admission and Length of Stay Criteria

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

13.1 Review Interval

Length of stay/payment authorization will not exceed State maximum standards.

13.2 Focused Review

Cases remaining in the hospital for sixty (60) days will be reviewed by a UM Physician.

Other cases, as defined by the UMC, will be subject to focused review.

14.0 SMHS Acute Psychiatric Hospital Services: Administrative Days

14.1 Description

Administrative days will be authorized by UM when a 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 at a minimum five (5) appropriate non-acute residential treatment facilities within a reasonable geographic area at least once a week until a beneficiary is placed or no longer requires that level of care. UM may waive the requirements of five (5) contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options. The weekly contacts must document briefly the status of the beneficiary and rationale warranting non-acute residential treatment, status of the placement option, the date of the contact, and the signature of the person making the contacts. The hospital will provide a copy of the beneficiary's chart for review on a weekly basis. The UM Clinical Review Specialist will monitor the beneficiary's chart on a weekly basis to determine if the beneficiary's status has changed.

14.2 Criteria

Payment for 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 residential 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 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.

- The medical record indicates at least on a weekly basis an assessment of level of care that supports placement in a non-acute residential treatment facility.

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

15.1 Definitions

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

15.2 Guidelines

Emergency admissions, whether to contract or non-contract hospitals, are exempt from prior authorization requirements. Contract hospitals and hospitals outside the ACBHCS MHP contracting network of providers will be reimbursed for acute psychiatric hospital services rendered when all necessary Medi-Cal medical necessity criteria is met.

To receive payment for an emergency admission, the provider must notify UM within twenty-four (24) 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.

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.

Hospital services rendered by Fee-for-Service (FFS) psychiatric units/facilities whose licensures are connected to a General Acute Care Hospital are Medi-Cal reimbursable for beneficiaries of all ages. Payment reimbursement authorizations occur via the TAR 18-3 and are submitted by UM to the Medi-Cal fiscal intermediary for payment reimbursement.

Freestanding psychiatric facilities (licensure not connected to a General Acute Care Hospital) are under what is referred to as the IMD Exclusion: admissions for beneficiaries between the ages of 22-64 years old are not Medi-Cal reimbursable; requires Short-Doyle reimbursement. ACBHCS policy requires that Short-Doyle reimbursement for inpatient hospital services occurs only when ACBHCS has a current contract with an identified inpatient facility. UM is to notify the ACBHCS Network Office of a non-contracted freestanding psychiatric facility within one business day of UM becoming aware that a 22-64 year old Alameda County Medi-Cal beneficiary has been admitted. ACBHCS Provider Relations, Claims Department remits payment upon verification of all necessary payment requirements.

16.0 SUD Residential Treatment

16.1 Overview of Referral to Residential Treatment

There are multiple entryways into SUD Residential Treatment. The below are the four portals that provide ASAM screening and referral to the residential treatment level of care and provider. Each portal is staffed with skilled clinicians who are state-certified alcohol and drug counselors; individually trained in the application of ASAM criteria and who receive supervision from Licensed Practitioners of the Healing Arts (LPHAs) or Certified AOD Counselor-Clinical Supervisors. Beneficiaries who are screened and referred to the residential treatment level or care will be given an assessment appointment with a specific residential provider within ninety-six (96) hours of the request.

Four (4) Portals:

1) Substance Use Residential 24/7 Helpline:

- Callers may be self-referred or referred by any number of referral sources (e.g. physical health care providers, mental health providers, County Child and Family Services, family member or friend etc.).
- If the telephonic screening seems insufficient to make a placement decision, then a clinician from CenterPoint will make an in-person appointment with the beneficiary at either the North or South County Office (whichever is most convenient for the beneficiary) within a time period not to exceed two business days.
- Please note: CenterPoint is the current Helpline contractor. The Alameda County ACCESS line will assume this responsibility- TBD. Crisis Support Services of Alameda County provides after-hours, weekends, and holiday coverage by trained crisis counselors who address emergencies immediately, provide information and support around non-emergent requests, and convey non-urgent messages to the Substance Use Residential Helpline staff, who contact the caller the next business day.

2) AB109 Criminal Justice Care Management (CJCM):

- In operation on weekdays during normal business hours.
- Persons with realigned AB109 offenses are referred by Alameda County Probation Department for assessment and referral, which is conducted by CenterPoint clinicians.
- CenterPoint clinicians receive beneficiary handoffs in person from Probation Officers at their North or South County offices.

3) Cherry Hill (Social Model) Detox:

- In operation 24/7.
- Refers beneficiaries into treatment as part of discharge planning.
- Hands off care management responsibility to CenterPoint clinicians who go onsite to Cherry Hill twice a week for warm handoffs. Once the handoff is made, a CenterPoint clinician conducts an ASAM screening and referral and follows up with beneficiaries periodically.

4) Drug Court:

- In operation weekdays for beneficiaries charged with drug-related crimes willing to engage in treatment as a plea bargain condition at a level of care determined by a Court clinician.
- The Drug Court clinician provides care coordination within substance use treatment, and at the clinician's recommendation, may be required to transfer to a more or less intensive treatment program.
- Once a beneficiary is referred to residential treatment, that residential provider takes over the responsibility for further re-assessment and transfers.

16.2 Initial Residential Treatment Prior Authorization Process

Prior Authorization for Residential Treatment services is required and authorization decisions to be rendered within twenty-four (24) hours from receipt of request.

- The beneficiary completes the scheduled assessment at the residential treatment provider site. The provider determines medical necessity by utilizing ASAM criteria and confirming whether or not the beneficiary currently articulates and exhibits symptoms consistent with a DMC included diagnosis and would benefit from the residential treatment level of care.

- Provider submits a Prior Authorization request to UM.

- Within twenty-four (24) hours from the receipt of the request, the UM Clinical Review Specialist obtains and reviews clinical information and renders either an initial authorization of up to thirty (30) days, or a “Denial”, or “Approved as Modified”, or “Pending” status. Authorization requests for after hours, County holiday or weekend admissions should be initiated by the Residential Treatment provider on the morning of the next business day.

- Residential Treatment providers will be trained and instructed to complete all Alameda County data system entries prior to submitting the prior authorization request to UM. In addition, the service entries are first to be entered under a non-billable Medi-Cal procedure code; only to be updated to a Medi-Cal billable procedure code upon receipt of the authorization from UM. Upon completion of all necessary updates, providers to notify ACBHCS Provider Relations, Claims Processing Unit.

16.3 Continuing Residential Treatment Authorization

- If a beneficiary and Residential Treatment provider agree that additional residential treatment services are clinically warranted, the provider will submit to UM a prior authorization for continuing services at least seven (7) calendar days prior to the initial or preceding authorization expiration date.

- The UM Clinical Review Specialist obtains clinical and treatment information, either telephonically and/or through clinical documentation, and makes medical necessity determinations and provides disposition/aftercare recommendations to ensure full and appropriate utilization of County resources. Authorization determines are rendered within twenty-four (24) hours from request receipt.

16.4 Pending or Denied Authorization Requests

If documentation received is incomplete or missing, UM will indicate the authorization as “Pending” and send the request for additional information to the provider, who shall respond within 24 hours. If requested information is not received within 24 hours, the prior authorization request may be denied due to untimeliness. If an adverse decision is rendered, the provider and beneficiary are notified. The notification will specify the

rationale for the decision, the non-covered dates or treatment period, and the appeal rights and procedures.

16.5 Length of Residential Treatment Authorizations

The length of residential services ranges from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90 day regimens will be authorized in a 365 day period. Adults aged 21 and over, may receive up to two continuous short-term residential regimens per 365 day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90 days per 365 day period. UM will track the two non-continuous stays in the County of Alameda, within their authorization process.

Perinatal and criminal justice beneficiary may receive a longer length of stay based on medical necessity. Perinatal beneficiaries shall receive a length of stay for the duration of their pregnancy, plus 60 days postpartum.

Residential treatment for adolescents may be authorized for up to 30 days in one continuous period. Reimbursement will be limited to two non-continuous 30 day regimens in any 365 day period. One extension of up to 30 days beyond the maximum length of stay may be authorized for 1 continuous length of stay in a 365 day period.

GLOSSARY

Clinical Review Specialist (CRS)

Clinical Review Specialists are licensed clinicians working in the UM Program, who monitor the delivery of care to determine appropriateness of service, quality of care, and reimbursement of services.

Pattern of Care

Pattern of care refers to an identified pattern in which a single type of service or constellation of services is provided, often reflecting an order of use of services. The focus is on continuity of care between services.

Prior Authorization

Prior Authorization is an approval of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Prior authorization does not guarantee payment.

Provider Profiling

Provider profiling is a process in which providers, who may be individuals or organizations providing a service, are described or profiled using variables to indicate practice patterns, referral sources, characteristics of population served, and other relevant information

Quality of Management Program Director

The Quality of Management Program Director reports to the ACBHCS Director and is responsible for oversight of the design, implementation and evaluation of Quality Improvement (QI) activities to improve the quality of client care and services provided and assures design is in compliance with relevant certification standards and local, State, and Federal regulations and standards of care.

Utilization Levels

Utilization levels refer to the amount of services or rate at which services are provided.

Utilization Management Program (UM)

The ACHBCS Utilization Management Program consists of a coordinated effort to ensure access to services while maintaining quality and cost effectiveness.

The program consists of review assessment of individuals receiving care and coordination of units that impact utilization of services.

Utilization Management (UM) Division Director

The UM Division Director reports directly to the Quality of Management Program Director and is responsible for the supervision and operation of an authorization unit that serves as a Point of Authorization for Medi-Cal and indigent service reimbursement, and provides oversight of ACBHCS resource utilization in terms of accessibility, efficiency, and quality.

Utilization Management (UM) Physician

The UM Physician reports clinically to the Medical Director. The UM Physician is a psychiatrist who provides clinical direction to the Utilization Management Program and who makes authorization adverse decision determinations.

Utilization Management (UM) Supervisor

The UM Supervisor reports directly to the UM Administrator and supervises Clinical Review Specialists, coordinates day-to-day unit functions, ensures appropriate staff coverage, and assists in UM administrative functions and related work as required.

Utilization Practice Patterns

Utilization practice patterns refers to identified pathways, steps, or routes in which health care events occur or care is rendered, usually within a program or type of service.

Utilization Trends

Utilization trends are identified tendencies or trajectories describing use of a service or group of services over time.