



## PENINSULA RSN

### UTILIZATION MANAGEMENT POLICIES AND PROCEDURES

**Policy Name:** AUTHORIZATION FOR OUTPATIENT SERVICES BASED ON MEDICAL NECESSITY

**Policy Number:** 7.01

**Reference:** 42 CFR 438.207, -.210;  
WAC 388-865-0150; DSHS Contract

**Effective Date:** 11/2005

**Revision Date(s):** 12/2010

**Approved by:** PRSN Executive Board

#### CROSS REFERENCES

- Form: PARS (Peninsula Authorization for Residential Services)
- Form: PRAT (Peninsula Regional Assessment Tool)
- Letter: Notice of Action Form Letter Template
- Letter: PRSN Authorization Notification Letter Template
- Letter: PRSN Letter of Ineligibility Template
- Policy: Corrective Action Plan
- Policy: Notice of Action Requirements

#### PURPOSE

To ensure the Peninsula Regional Support Network (PRSN), network providers, and the subcontracted Administrative Service Organization (ASO), share a standardized process for authorizing care based on the medical necessity established by the PRSN.

The PRSN has adopted a “medical necessity” definition that includes the state Washington Administrative Code (WAC) and contract definition for medical necessity and the statewide Access to Care standards. This policy applies to outpatient, including residential services, authorization determinations for Medicaid and non-Medicaid individuals.

- Non-Medicaid outpatient and residential services are authorization within available resources.

## DEFINITIONS

Access to Care Standards are defined as standards established by the mental health division that PRSN must implement for the purposes of determining minimum eligibility for Medicaid enrollees seeking admission into mental health outpatient services.

Authorization is defined as the power and authority exercised by PRSN, or their designee ASO, to approve and non-approve authorization of intake assessments, outpatient, inpatient, and residential services for individual seeking mental health services.

Consumer means a person who has applied for, is eligible for or who has received publically funded mental health services.

- For a child under the age of thirteen, the definition of consumer includes the parents or legal guardians.
- For a child thirteen years or older who provides consent for their parents or legal guardians to be involved in the treatment planning, the definition of consumer includes the parents or legal guardians.

WAC defines Medical necessity or medically necessary as a term to describe a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is not other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this definition “course of treatment” may include mere observation or, where appropriate, no treatment at all.

Contract defines Medical necessity as it appears in WAC (as listed above) and “Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual’s impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual’s unmet need.”

Request for Services is defined as the point in time when a request for mental health services are sought or applied for through a telephone call, in person, or receipt of a written request through any of the following access points.

- Contacting PRSN
- Contacting CommCare
- Contacting the Network Provider
- Crisis Services

## PROCEDURE

1. The PRSN has adopted a “medical necessity” definition that includes the WAC and contract definitions for all levels of care. In addition, the PRSN admission criteria for “medical necessity” include the statewide Access to Care standards.  
Non-Medicaid outpatient and residential services are authorization within available resources.
2. The PRSN contracts with an administrative service organization (ASO) to provide regional authorization determinations for PRSN services requiring authorization for Medicaid and non-Medicaid individuals.
  - a. All authorization clinical reviews are conducted through the completion of a PRSN treatment authorization request form electronically transmitted to the ASO. The authorization determination, approval/ denied, is indicated on the electronically transmitted request form and electronically returned to the provider agency with a determination.
    - For urgent or expedited requests, the authorization request can be conducted telephonically. The network provider is responsible for submitting the authorization forms retrospective of a verbal/ telephonic authorization.
    - The electronic transmission between the network provider and ASO complies with the HIPAA on-line technology standards.
  - b. The ASO is contracted to use the formally adopted PRSN utilization policies, Utilization Management Plan, Levels of Care which includes the Access to Care standards, and related guidelines when making authorization determinations.
  - c. The PRSN network providers are required to request services by completing the appropriate authorization request, submitting supporting documentation, and communicating any unique circumstances to the ASO for an authorization determination.
3. The PRSN uses the following outpatient authorization tools:
  - a. PRAT (Peninsula Regional Assessment Tool) form for outpatient services authorization.
    - A PRAT authorization extension is requested as a narrative statement stated on the Initial Admission to Outpatient Services (PRAT form) for authorizations requests that exceed the contract limit of 14 days.
  - b. PARS (Peninsula Authorization for Residential Services) form for brief and intensive long-term residential services authorization.

4. All the PRSN authorization tools require review of the PRSN specific level of care standards that include the medical necessity criteria.
  - The ASO is responsible to adhere to the PRSN Level of Care standards, when reviewing authorization requests.
  - PRSN monitors for inter-rater reliability and utilization trends.
5. Following an Intake Assessment. The ASO utilization care managers review an authorization for services request, following an intake assessment, on the PRAT for medical necessity criteria in making the authorization determination.
  - a. Authorization requests, following an Intake Assessment, are reviewed by a mental health professional who has the appropriate clinical expertise to determine if the individual's current condition/diagnosis meets PRSN adopted medical necessity criteria as defined above.
    - In consultation with a specialists, if required
  - b. Standard authorization decisions are made as expeditiously as the individual's mental health condition requires and within state established timeline. The authorization determination must occur within 14 (fourteen) days of the date of the intake assessment was initiated.
    - The network provider is required to request an authorization extension if medical necessity cannot be established and /or additional time is required beyond the 14 (fourteen) day limit.
    - An extension request can only be approved for up to 14 (fourteen) additional calendar days.
  - c. An expedited authorization is made in cases when following the standard time frame could seriously jeopardize the consumer's life, health or ability to attain, maintain, or regain maximum function. An expedited decision must be made as expeditiously as the individual's condition requires but not to exceed 3 (three) working days from the receipt of the request for service.
  - d. Approved admission authorizations must meet the Access to Care Standards.
  - e. For non-Medicaid individuals, all the above apply, in addition to within available resources and other admission criteria identified in the PRSN Levels of Care.
  - f. Individuals are notified, in writing, of all outpatient determinations.

- The PRSN mails an authorization letter, along with the PRSN handbook within 14 (fourteen) days of the determination to all individuals authorized for services.
  - CommCare mails NOA and letters of ineligibility to individuals within one working day of the determination.
6. Continuing Stay and/or Concurrent Review. The ASO utilization care managers review an authorization for services request for outpatient continuing stay and/ or concurrent service authorization on the PRAT. The PRAT must document that medical necessity is established and additional criteria is met for the requested level of care.
- a. Continuing Stay and Concurrent services requests are reviewed by a mental health professional who has the appropriate clinical expertise to determine if the individuals current condition/diagnosis meets PRSN adopted medical necessity criteria, PRSN Level of Care standards, and contract elements for the reauthorization of requested service.
  - b. In reviewing the request for authorization, the ASO is responsible for ensuring the requested services are clinically and fiscally sound.
  - c. For non-Medicaid individuals, all the above apply, in addition to within available resources and other continuing care criteria identified in the PRSN Levels of Care.
7. Service Denial Authorization Decisions. The ASO is contracted to make the service denial authorization decisions for Medicaid and non-Medicaid individuals. Prior to a service denial decision based on clinical criteria, the ASO will:
- Request additional information, if needed.
  - Conduct a peer to peer review, to include staff with clinical expertise with the individuals specific need, and review all of the PRSN required documentation and additionally requested information.
8. Service Denial Notification Requirements.
- a. In the event requested services are denied, the ASO mails a service denial notification letter within one day of making the denial determination to the individual at the last known address.
    - For Medicaid: The notification is provided on a PRSN Notice of Action (NOA) letter. The PRSN uses the NOA template provided by the Department and inserts the information specific to the PRSN.  
When a Medicaid individual is determined by the provider to not meet the Access to Care standards, the PRSN Letter of Ineligibility is sent.

The ASO is responsible for sending these letters to an individual, a copy to the network agency, and PRSN office.

- For non-Medicaid individuals: The letter of ineligibility notification states the individual has been found ineligible for services and the reasoning, the information includes how to request a second opinion if the decision was based *on clinical criteria versus resource limitations*, and local crisis service contacts. The letter may include referral information, such as other community resources that could more appropriately serve the individual.

The ASO is responsible for sending this letter to the individual, a copy to the network agency, and PRSN office.

- b. The NOA letter includes an explanation of the individual's right to appeal the decision and is:
  - In writing.
  - In the individual's primary language and be easily understood.
  - Explains the action the PRSN, or its contracted provider, has taken or intends to take.
  - Explains the reasons for the action.
  - Explains the individual's or community mental health agency's right to file an appeal.
  - Explains the procedures for exercising the individual's rights.
  - Explains the circumstances under which expedited resolution is available and how to request it.
  - Explains the individual's rights to have services continue pending a resolution of an appeal, how to request that services be continued, and the circumstances under which the consumer may be required to pay the costs of these services and be mailed as expeditiously as the individual's mental health condition requires.
  - For denial of payment, at the time of any action affecting the claim.
9. Authorization Reporting Requirements and System Monitoring
  - a. All authorization determinations, approved and denied, made by the ASO for PRSN services is recorded by the ASO and the network provider making the request.
    - The ASO enters the authorization decision into Profiler, the network database system.
  - b. Monthly utilization data reports are provided from the ASO and reviewed monthly by the Utilization Management Committee

- c. All service denials, including NOA letters, are copied and mailed to the PRSN office for 100% review within one day of the denial decision.
  - The submitted utilization data reports included service denial decisions. Denials will be tracked and reported to the Department in accordance with Exhibit N.

## **MONITORING**

This policy is mandated by statute and contract.

1. The PRSN monitors this policy through the use of the PRSN:
  - Annual PRSN Provider and Subcontractor Administrative/ Subdelegated Review
  - Monthly Provider Chart Reviews
  - Exhibit N Provider Complaint and PRSN Grievance Tracking
  - Biennial Provider Quality Review Team review
  - Quarterly Provider Performance Reports
  - Utilization Committee activities, such as the ASO case review
  - Quality Management Plan activities, such as review targeted issues for trends and recommendations
2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for PRSN approval.