Utilization Management Process
For BBHWP Clients
October 2016

Overview

The Bureau of Behavioral Health Wellness and Prevention (BBHWP) Utilization Review (UR) process is used to authorize, revise, or deny payment for treatment. BBHWP is the payer of last resort. BBHWP will only authorize payment for services for individuals who are not currently eligible to enroll with any other payer source or the services received are services which are "not a covered benefit" under another payer source. The Utilization Review Team will review a patient's intensity of need and intensity of service utilizing the diagnostic criteria, ASAM criteria and WHODAS, an individualized and targeted treatment plan, and the appropriate treatment, level of care, and length of time needed to accomplish the treatment.

Agencies will be required to submit a synopsis of clinical information per policy requirements justifying a treatment plan. If treatment is authorized BBHWP will pay for services at the established FY2017 rate. Services currently requiring a UR are transitional housing, residential treatment (Level 3.1, 3.2WM, or 3.5), and targeted case management (TCM, for established pilot program participants).

The Utilization Review Procedure

1. The provider will submit authorization requests for treatment to the BBHWP utilization review team via the secure file transfer portal.

2. A BBHWP employee will review the authorization request for BBHWP eligibility. A BHPT employee verifies that the patient's presenting symptoms meet medical necessity guidelines. Medical Necessity is defined as a health care service or product that is provided for under the BBHWP policy and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability. The determination of medical necessity is made on the basis of the individual case and takes into account: type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies, level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available. Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient, Services are provided for mental/behavioral reasons rather than for the convenience of the recipient, the recipient's caregiver, or the health care provider. Medical Necessity shall take into account the ability of the service to allow recipients to remain in a community based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.

3. Emergency level of care requests decisions will be made within 24 hours.
    a. Emergency requests should be uploaded to the SFTP site along with e-mail notification to the provider's treatment analyst.
    b. An emergency is deemed if the clients ASAM severity risk rating is a 3 or higher in Dimensions 1, 2 and/or 3. Immediate action maybe required (4b) for dimensions 4, 5 or 6 if the patient has an urgent need that would require a more restricted level of care.
    c. ASAM severity risk rating of a 4 in dimensions 1, 2 and/or 3 or (4b) for dimensions 4, 5, and/or 6 would require placement into a Medically Managed Inpatient unit and would not qualify the client for placement
4. Retroactive Reviews: If a client enters treatment on a Friday or Saturday, the provider will electronically submit a request to BBHWP on the weekend and a retroactive review will be conducted by the 2nd business day following the weekend to determine if the client met criteria for the level of care they were placed in.
5. The provider will receive notification of approval/denial, with an authorization number, via the SFTP site.
6. If a denial is determined, the provider has 48 hours to provide additional information justifying level of care.
7. Providers must request additional units of service through electronic submission to the BBHWP UM Team 48 hours prior to expiration of current approval based on continued service or transfer criteria prior to additional services being approved.

Determining Level of Care and Length of Service

Assessment

- DSM 5 Criteria: Specific criteria must be provided including a severity rating of Mild, Moderate, Severe severity for Substance Use and criteria and severity per specific mental health diagnosis is applicable.
- ASAM Six Dimensional Assessment: ASAM Severity Rating Scale, 0-4 for each Dimension including:
    - Dimension 1: Acute Intoxication and/or Withdrawal Potential
    - Dimension 2: Biomedical Conditions and Complications
    - Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
    - Dimension 4: Readiness to Change
    - Dimension 5: Relapse, Continued Use, Or Continued Problem Potential
    - Dimension 6: Recovery/Living Environment
    - An overall rating of Low, Moderate, or High must all be provided.
- WHODAS 2.0 Functional Assessment Tool
    - A WHODAS Functional Score must be provided at initial request and for continued service requests thereafter.
- ASAM Continued Service Criteria (Documentation of the following areas needs to be provided including stated goals within appropriate dimensions determined by clients level of functioning utilizing the DSM 5 Criteria and WHODAS function assessment tool).

    - Client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals.
    - Client is not making progress, but has the capacity to resolve his or her problems. Client is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals.
    - New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the client is receiving treatment is therefore the least intensive level at which the client's new problems can be addressed effectively.
- ASAM Transfer/Discharge Criteria (Documentation of the following areas needs to be provided including stated goals within appropriate dimensions determined by clients level of functioning utilizing the DSM 5 Criteria and WHODAS function assessment tool).
    - Client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Continuing the chronic disease management of the client's condition at a less intensive level of care is indicated.
    - Client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. The client is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated.
    - Client has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated.
    - Client has experienced an intensification of his or her problem(s) or has developed new problems(s), and can be treated only at a more intensive level of care.

Recommended Protocols

- Submit electronically to BBHWP UM Team Admission Criteria, Continued Service, Transfer and Discharge Criteria to determine level of care.
- BBHWP reviews assessment criteria and determines approval for the initial provisional length of service based on level of care.
    - Level 1: up to 30 Days
    - Level 2.1: up 90 Days

    - Transitional Housing: up to 30 Days
    - Level 3.1: up to 21 Days
    - Level 3.5: up to14 Days
    - Level 3.2WM to 5 Days
- Providers need to request additional units of service through electronic submission to BBHWP UM Team 72 hours prior to expiration of current approval based on continued service or transfer criteria prior to additional services being approved. (Documentation of the continued service or transfer needs to be provided including stated goals within appropriate dimensions determined by client's level of functioning utilizing the DSM 5 Criteria and WHODAS function assessment tool).
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    - Level 1: up to 14 Days
    - Level 2.1: up to 30 Days
    - Transitional Housing: Up to 14 Days
    - Level 3.1: Up to14 Days
    - Level 3.5: Up to 7 Days
    - Level 3.2WM Up to 2 Days

Appeals Process

Providers have the right to appeal authorizations denying treatment. If a provider, receives an authorization denial from a BBHWP UM Team member, the provider should immediately request the specific reason(s) for denial and secondary review by the BBHWP UM Manager. If the additional review does not result in treatment authorization, the provider should next immediately request a Peer-to-Peer Review. A Peer-to-Peer Review must be scheduled by BBHWP within 24-hours of the request, and also occur within that time period, unless the provider requests a delay. If not, temporary authorization is granted for up to 5 days until the Peer-to-Peer Review can occur will be granted.

If the Peer-to-Peer review does not result in an approval the provider may then request a formal appeal to the BBHWP's Bureau Chief. BBHWP will formally notice the provider of the final decision and future appeal options per NAC 439.345.

An agency can appeal that action to the Division Administrator and request a hearing. Once the facility requests an appeals to the Administrator of the Division, then BBHWP offers the appellant an opportunity for an informal resolution (pre-hearing meeting) as required by NAC 439.345and.346. At the pre-hearing, if BBHWP is unable to resolve the case, a request is sent to the Administrator of the Division to schedule a hearing (most cases are resolved at this level).

BBHWP will make continual attempts to resolve the case prior to the hearing, or at any time, the provider may withdraw their request for a hearing. If all efforts to informally resolve the case are unsuccessful, then the hearing on appeal is conducted. BBHWP gets an opportunity to present evidence and so also does the provider. The hearing officer makes a recommendation to the Administrator of the Division and the Administrator decides whether to uphold the denial or approve the authorizations. If they are denied, then the facility can

request judicial review of the case and then a judge will decide to uphold the decision of the Administrator or overturn the decision.

Appeals must be submitted, in writing, for review no later than 30 calendar days from the date of denial on the authorization. If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 30 calendar days.

Auditing File Protocol

Periodic BBHWP Internal reviews of Electronic Health Records will be done to determine if documentation supports admission, continued service and transfer to a higher or lower level of care. Random audits may occur outside of the traditional monitoring periods.

If a program is found to be out of compliance based on an audit review by a BBHWP UM Team member graded sanctioned will be required including:

- A corrective action plan submitted to BBHWP within 10 business days of receipt of letter from BBHWP stating the non-compliance issues.
- BBHWP has 10 business days to review and to respond to determine if the corrective action plan is acceptable.
- The provider can request technical assistance from BBHWP to help address issues identified through the audit process.
- BBHWP will do an unannounced follow up audit review which will take place in a timeframe suitable to the non-compliance issues sited.
- If the provider does not correct the stated deficiencies within the timeframe provided the following actions may be taken:
    - Contract terminated by BBHWP for a period of at least 1 year at which time the provider can reapply for a contract.
    - The provider may have to pay a partial or full repayment back to BBHWP for services that did not meet medical necessity identified through the audit process.