SANTA CLARA COUNTY
Behavioral Health Services

NEW MEGA REGS POLICY & PROCEDURE (P&P) APPROVAL REQUEST FORM

I. P&P INFORMATION

Assigned Policy Name: Utilization Management

Assigned Policy Number: 6000

Mega Regs Policy Area(s): Mark All That Apply

☐	Plan Administration and Organization	☐	Provider Network
☐	Scope of Services	☐	Documentation Requirements
☐	Financial Reporting Requirements	☐	Coordination and Continuity of Care
☐	Management Information Systems	☐	Beneficiary Rights
☐	Quality Improvement System	☐	Beneficiary Problem Resolution
☒	Utilization Management Program	☐	Program Integrity
☐	Access and Availability of Services	☐	Reporting Requirements

Submitted by: Victor Ibabao Date: 3/29/2018

Policy developed by: Whitney Webber

Attach P&P Document For Review In this Section

II. APPROVAL

Section A: HHS Compliance and County Counsel

HHS Compliance: DocuSigned by: victoria phan 3527B4B4F12742C... Date: 4/6/2018

County Counsel: DocuSigned by: Lorraine Van Kirk C2D9923D8017445... Date: 4/11/2018

Section B: BHSD Executive Director

BHSD Executive Director: DocuSigned by: Toni Tullys AB2AABE6ED30409... Date: 4/11/2018

Note - A copy of the Approved Mega Regs P&P Form will be emailed to: BHSD Compliance Unit

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

X	**BHSD County Staff**
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X	**Specialty Substance Use Treatment Services**

Title: UTILIZATION MANAGEMENT PROGRAM

Approved/Issue Date:	**Behavioral Health Services Director:**	
Last Review/Revision Date:	**Next Review Date:**	**Inactive Date:**

REFERENCE:

- 42 Code of Federal Regulations (C.F.R.) §438.62(b)(1)-(2) Continued services to enrollees
- 42 Code of Federal Regulations (C.F.R.) §438.114(c-e) Emergency and post stabilization services
- 42 Code of Federal Regulations (C.F.R.) §438.208(b)(1)-(4) Coordination and continuity of care
- 42 Code of Federal Regulations (C.F.R.) §438.210(b), §438.210(d)(1)-(2), §438.210(e) Coverage and authorization of services
- 42 Code of Federal Regulations (C.F.R.) §438.242(a)(b)(1)-(4) Health information systems
- 42 Code of Federal Regulations (C.F.R.) §438.330(a)(1)-(3), §438.330(b), §438.330(c), §438.330(e)(1) Quality assessment and performance improvement program
- 42 Code of Federal Regulations (C.F.R.) §438.910(d) Parity requirements for financial requirements and treatment limitations
- 9 California Code of Regulations (CCR) §1810.405(c) Access Standards for Specialty Mental Health Services
- 9 California Code of Regulations (CCR) §1820.205 Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services
- 9 California Code of Regulations (CCR) §1820.220 MHP Payment Authorization by a Point of Authorization
- 9 California Code of Regulations (CCR) §1820.230 MHP Payment Authorization by a Utilization Review Committee
- California Department of Health Care Services Fiscal Year 13-18 Contract, Exhibit A, Attachments 1, 3-6, 10
- County of Santa Clara Behavioral Health Services Department (BHSD) Policy 10000 Coordination and Continuity of Care
- Intergovernmental Agreement for Substance Use Disorder Services for Fiscal Year (FY) 2016-17 through FY 2018-19.

SANTA CLARA COUNTY
Behavioral Health Services

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POLICY:

The Behavioral Health Services Department (BHSD) Utilization Management (UM) program supports the delivery of services provided by its County and Contracted partners, and ensures delivery of high quality, medically necessary care through appropriate utilization of resources in a cost effective and timely manner. The UM program is a key component of the BHSD's "Quality Assessment and Performance Improvement" (QAPI) Division. The UM Program operates under the guidance of the BHSD's Director, Quality Management Executive Director, Medical Director, and Utilization Management Division Director. The program is designed to detect and address over and underutilization of services, and evaluates medical necessity and appropriateness of services provided to Medi-Cal beneficiaries prospectively, concurrently, and retrospectively. This policy outlines the standards and guidelines that detail how the BHSD and its provider network system comply with the federal laws and Department of Health Care Services (DHCS) contract requirements pertaining to UM responsibilities.

It shall be the policy of the Behavioral Health Services Department (BHSD) to have a comprehensive, integrated Utilization Management (UM) program that meets the regulatory requirements of the DHCS Contract, California Code of Regulations (CCR), and Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR). The UM program shall provide verification that individuals who are Medi-Cal beneficiaries served by the BHSD and its provider network (Community Based Organizations, or CBOs) receive the right service, at the right time, and in the right amount sufficient to meet their needs.

The UM program has the following components:

- **Utilization Management (UM)**

Utilization Management Affirmation Statement: BHSD does not provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

BHSD shall maintain a health information system that collects, analyzes, integrates, and reports utilization data. BHSD shall conduct performance monitoring activities for UM/UR throughout its operations in order to detect both underutilization and overutilization of services. BHSD shall take steps to assure that decisions for UM shall be consistent with its practice guidelines.

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

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X	**Specialty Substance Use Treatment Services**

Title: UTILIZATION MANAGEMENT PROGRAM

- **Utilization Review (UR)**

BHSD shall implement procedures to deliver care to and coordinate services for all of its beneficiaries, including a review of its UM activities annually, ensuring consistency in the authorization process and beneficiary and provider satisfaction. This includes, but is not limited to, reviewing services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports. This also includes how to address data from quality improvement activities specific to enrollee satisfaction and performance of providers.

BHSD will adopt a process of inter-rater reliability to ensure consistency to which the medical necessity criteria are applied.

- **Care Coordination**

BHSD shall ensure continuity and coordination of care, which may include but is not limited to, transition or transfer to appropriate level(s) of care, Whole Person Care, long-term services and supports, and Non-Medical Transportation (NMT), for mental health, substance use disorder treatment services, and physical health care providers. BHSD shall coordinate between settings of care, including appropriate discharge planning for short term and long term hospital and institutional stays, with Fee-for-service Medical, and with other human services and community service agencies used by beneficiaries. In addition, BHSD shall assess the effectiveness of any agreements to integrate care with physical health care plans. BHSD will ensure each beneficiary has an ongoing source of care appropriate to his or her needs, and a person or entity designated for coordinating services accessed by the beneficiary. BHSD may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose. Care coordination efforts shall ensure that the beneficiaries' privacy is protected.

- **Service Authorization**

The UM program is responsible for authorizing the following services:

- Day Rehabilitation (DR) & Concurrent Therapeutic Services
    - Payment authorization for DR and concurrent therapeutic services cannot exceed one month per request. Payment authorization for concurrent therapeutic services cannot exceed the end date of the associated DR authorization end date.

- Initial payment authorization requests for DR (5 days per week or less) and concurrent therapeutic services must be received by the QA Program no more than two weeks before and no more than two weeks after the previously authorized end date.
- Initial payment authorization requests for DR (6 days per week or more) must be received by the QA Program prior to beginning services. Continued payment authorization requests for DR (6 days per week or more) must be received by the QI Program no more than two weeks before but prior to the previously authorized end date.
- The date a complete (i.e., all sections on the form are correctly filled out) payment authorization request is received by QA establishes the official date by which the request meets or does not meet the deadline, the authorized start date will be adjusted accordingly.
- Justification for initiation of services must include the following: (1) a mental health diagnosis that meets medical necessity criteria, and (2) reason for requested services (e.g., client goal that this service will address), and if concurrent therapeutic services, the type(s) of services as described in the treatment plan.
- Justification for continuation of services must include the following: (1) a mental health diagnosis that meets medical necessity criteria, and (2) client's progress or setbacks during the previous authorization period (i.e., attendance and participation, accomplishments, etc.), and (3) reason for extension of services at this level of care.

- Fee-for-service (FFS)
  - Medically necessary limited inpatient and outpatient services including examination, evaluation, individual or group treatment, and medication prescription and monitoring. Services can be provided in acute care hospitals, individual, group or family therapy services in outpatient or clinic settings, and various partial day or day treatment programs. The majority of the FFS contractors are primarily psychiatrists and psychologists, who provide office-based direct services.
- Inpatient Hospitalization & Treatment Authorization Requests (TARS)

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

X	**BHSD County Staff**
X	**Contract Providers**
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X	**Specialty Substance Use Treatment Services**

Title: UTILIZATION MANAGEMENT PROGRAM

- Institute for Mental Disease (IMD) admissions
    - All admissions to the IMDs are subject to the Prior Authorization Process described in Exhibit "B" of the contract and, in addition, must meet County's criteria for such treatment. The length of stay in this setting is approved for up to 85 days. Extensions may be granted if the client is deemed appropriate for this level of care. Clients entering this setting must either be on a temporary or permanent conservatorship.
- Non-Emergency Medical Transportation (NEMT)
    - Refer to "California Department of Health Care Services Managed Care All Plan Letter 17-010 (REVISED)" dated July 17, 2017
- Out of plan service authorization requests (SARs, Presumptive Transfers)
- Partial hospitalization program (PHP)
    - The PHP will be Dual Diagnosis Capable (DDC) to address the relationship between the mental and substance-related disorders (SUD). Level 2.5 PHP will have direct access to psychiatric, medical, and laboratory services, and are designed to meet the identified needs which warrant daily monitoring or management, but which can be appropriately addressed in a formal structured outpatient setting. The program will discern their effect on the client's readiness to change and relapse and recovery environmental issues. Readiness to change needs will be assessed for both substance abuse (SU) and mental health problems.
- Residential treatment
    - Crisis Residential: Beneficiaries entering into this treatment setting must have an accepted mental health diagnosis or exhibit acute symptoms of mental illness and at risk for re-hospitalization. The length of stay in this setting is approved for up to 21 days. Extensions may be granted if the client is deemed appropriate for this level of care.
    - Supplemental Residential Care Facilities
        - Provides enhanced individualized beneficiary services in addition to standard Residential Care Facility (RCF) required services. Beneficiaries entering into these services have a level of functioning,

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

X	**BHSD County Staff**
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X	**Specialty Substance Use Treatment Services**

Title: UTILIZATION MANAGEMENT PROGRAM

symptoms, and psychiatric history which necessitate service intervention to maintain clients in community settings. This includes individuals who may suffer from an 'institutionalized' syndrome including increased passivity, lack of confidence, and lack of knowledge about the community. These beneficiaries may have secondary medical, developmental and/or substance abuse issues. RCFs will assist clients in improving skills needed to move to a less restrictive, more independent living situation. The length of stay in this setting is approved for up to six (6) months. Extensions may be granted if the client is deemed appropriate for this level of care.

- Skilled Nursing Facilities (SNF)
  - The BHSD contracts with skilled nursing facilities to provide medical and psychiatric services for adults 18 years of age and older and residents of Santa Clara County. All clients must have a primary psychiatric diagnosis and have a medical condition that requires a skilled nursing level of care. All services must be pre-authorized by the 24 Hour Care Unit. Clients requiring a locked SNF must either be on temporary or permanent LPS conservatorship.
- SUTS Residential: The Behavioral Health Services Department–Substance Use Treatment Services Managed Care Plan (BHSD-SUTS MCP) manages residential capacity, authorization, and placement. All referrals to residential must meet eligibility for medical necessity, ASAM level of care criteria (American Society for Addiction Medicine) and be authorized by the Managed Care Plan (MCP) Quality Management (QM). Residential 3.1 is appropriate for those who need supportive living in conjunction with low-intensity treatment. Residential 3.3 is for beneficiaries who have cognitive impairments and need a slower pace while receiving high intensity treatment. Residential 3.5 is appropriate for beneficiaries who are in imminent danger and require 24 hour stabilization services.

- Other Medi-Cal beneficiary services as appropriate

The authorization requirements shall comply with parity requirements in specialty mental health and substance use disorder benefits, and shall at least include a beneficiary's request for the provision of a service.

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

X	**BHSD County Staff**
X	**Contract Providers**
X	**Specialty Mental Health**
X	**Specialty Substance Use Treatment Services**

Title: UTILIZATION MANAGEMENT PROGRAM

Emergency inpatient psychiatric services are not subject to prior authorization, whether the admission is voluntary or involuntary. BHSD shall authorize out of network services when a beneficiary with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospitals or psychiatric health facility services. Following an emergency, we will follow-up with appropriate care.

All standard authorization decisions and notice will be processed as the beneficiary's health condition requires and no more than 14 calendar days following receipt for request for service, with a possible extension of up to 14 additional days, if requested by the client or provider. Expedited authorization decisions and notice, which could seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function will be processed no later than 72 hours after receipt of the request for service. BHSD may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if BHSD justifies a need for additional information and how the extension is in the beneficiary's interest. BHSD shall act on an authorization request for treatment for urgent conditions within one (1) hour of the request.

Licensed/waivered behavioral health staff will be responsible for all authorization decisions. Relevant clinical information will be obtained and used for authorization decisions. The statewide medical necessity criteria will be utilized in authorization decisions. When appropriate, the requesting provider will be consulted prior to making authorization decisions.

Denials will be clearly documented and communicated in writing to clients and providers. Written deny notice to the client includes deny decision to a service request or to authorize a service in an amount, duration, or scope that is less than requested. Such notices will include information about the client problem resolution process. Appeals will be addressed through the Beneficiary problem resolution process. Please refer to BHSD P&P 12000.

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

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X	**Specialty Substance Use Treatment Services**

Title: UTILIZATION MANAGEMENT PROGRAM

DEFINITIONS:

Appeal. A review by BHSD or Contract Agency of an adverse benefit determination.

Assessment. A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.

Beneficiary. A Medi-Cal recipient who is currently receiving services from BHSD or a BHSD contracted provider.

Emergency. A Condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency (Health & Safety Code § 1797.07).

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

X	**BHSD County Staff**
X	**Contract Providers**
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X	**Specialty Substance Use Treatment Services**

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PROCEDURE	
Responsible Party	**Action Required**
Quality Improvement Coordinators or Designee	Service Authorizations • Day Rehabilitation (DR) & Concurrent Therapeutic Services ○ Receives & reviews payment authorization form from County and Contract providers. ○ Approves, denies, or modifies the request. Returns incomplete forms to the provider. Consults with the designated contact person, if necessary. Faxes the results of the review to the contact person. • Fee-for-service (FFS) ○ Receives the Assessment and Treatment Summary (ATS) form from provider who is requesting services on behalf of beneficiary; ○ Verifies insurance eligibility and confirms the beneficiary is not receiving services from another insurance plan; ○ Approves, denies, or modifies the request; ○ If approved or modified, a profile is created for new beneficiaries using the Medi-Cal Client Identification Number (CIN#), otherwise, existing profile is used. Four (4) visits are pre-authorized. • Out of plan service authorization requests (SARs, Presumptive Transfers) ○ Verifies Medi-Cal eligibility, determines status (AAP, KinGAP,

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

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X	**Specialty Mental Health**
X	**Specialty Substance Use Treatment Services**

Title: UTILIZATION MANAGEMENT PROGRAM

Presumptive Eligible)

- Accepts AAP Medi-Cal referrals in the same manner as beneficiaries of Santa Clara County.
- Accepts KinGAP Medi-Cal referrals to the extent resources are available.

- On acceptance of referral, submits a Service Authorization Request (SAR) and cover letter to the placing county MHP, requesting a 12 month authorization for all services on an as needed basis.
- On receipt of signed SAR from county of origin, refers clients to appropriate service provider.
- Forwards the Referral letter and signed SAR to the provider program.
- Maintains SAR records.

- SUTS Residential Treatment
  - Reviews all ALOC assessments for authorization of residential ASAM level of care services. When authorized, QIC notifies the referring and receiving parties either verbally or in writing. QIC then notifies provider and placement proceeds.
  - In the event that the ALOC assessment does not meet medical necessity or other ASAM criteria for a residential level of care, the referring provider shall refer and coordinate care to the most compatible and appropriate level of services for the beneficiary.
- Other Medi-Cal beneficiary services as appropriate

Care Coordination

Refer to BHSD P&P 10000 Coordination and Continuity of Care for procedures on care coordination.

SANTA CLARA COUNTY
Behavioral Health Services

Policy & Procedure Number: BHSD # 6000

X	**BHSD County Staff**
X	**Contract Providers**
X	**Specialty Mental Health**
X	**Specialty Substance Use Treatment Services**

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	Utilization Review Monitors provider coordination of care efforts and service authorizations through prospective, concurrent and retrospective record reviews and audits. This may include, but is not limited to, Partial Hospitalization Services and Therapeutic Behavioral Services (TBS).
TARS Utilization Review Committee	Service Authorizations Inpatient Hospitalization & Treatment Authorization Requests (TARS) • Review the medical record submitted and approve or deny Acute and/or Administrative service dates requested on the Treatment Authorization Request (TAR); • Ensure all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by a physician or, at the discretion of the County, by a psychologist for beneficiaries admitted by a psychologist and who received services under the psychologist's scope of practice; • Notifies the provider of the decision to approve or deny Acute and/or Administrative service date re-imbursement for inpatient psychiatric hospital service dates requested on the TAR.

24 Hour Care Team	Service Authorizations
	
	Institute for Mental Disease (IMD) admissions and Residential Treatment (mental health facilities):
	
	• Review the referral sent in from providers, approve or deny it based on medical necessity
	
	  • Review all relevant clinical and medical information to determine medical necessity
	
	  • Staff has 24 hours to review the referral and respond to providers

	• Once referral approved and client admitted into a facility, an admission notice should be received by 24 Hour Care from the admitting facility for billing purposes. • If denied or needing more information, staff will contact the provider directly. • Referring providers can appeal the denial by contacting 24 Hour Care directly at 408-885-7580 and ask for the officer of the day. Non-Emergency Medical Transportation (NEMT) • Review the DHCS approved Physical Certification Statement (PCS) form to determine appropriate level of service for NEMT • Ensure that the provider's decisions regarding NEMT are not restricted by the DHCS contract and are medically necessary • Verify the lowest cost type of NEMT transportation (i.e. ambulance, litter van, wheelchair van, air) that is adequate for the medical needs of the beneficiary • Submit data from the PCS form to DHCS
Clinical Standards Program	Disseminates practice guidelines to all affected providers. Shares new or modified practice guidelines at quality assurance (QA) workgroup meetings. Assures that decisions for utilization management shall be consistent with the Practice Guidelines. Focus is on clinical practices and clinical practice quality, development, support, and standards.
Decision Support & Data Management	In collaboration with HHS IS, establishes and maintains a health information system that collects, analyzes, integrates, and reports utilization data at least monthly, including both underutilization and overutilization of services. Ensures accuracy of utilization data. Monitors timeliness of authorization decisions.
Research & Outcome Measurement	Develops and helps implement an inter-rater reliability audit tool for staff to use who are involved in UM decision making.

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Division Directors	Establishes criteria to evaluate medical necessity in collaboration with clients and providers for UM decisions. Acts on recommendations from the Utilization Management Committee that impact their functional area. Ensures training and technical assistance to address gaps in the delivery of high quality, medically necessary care.
Utilization Management Committee	Responsible to the Utilization Management Division Director and Medical Director. The UM Committee (UMC) reports directly to the Performance & Quality Improvement Committee (PQIC). The UMC responsibilities are designed to determine the extent to which care delivered to the County of Santa Clara beneficiaries meets the goals and objectives of the overall UM program.
Utilization Management Division Director	Develops and maintains written policies and procedures for and description of the Utilization Management program. Works towards compliance of the UM program with regulatory requirements and NCQA standards. Conducts annual review of the Utilization Management and Authorization program to evaluate medical necessity, appropriateness, and efficiency of services, and evaluate client and provider satisfaction with the UM process. Helps establish necessary quality improvement infrastructure to improve the UM process.
Quality Management Executive Director	Acts on recommendations for revisions to the Quality Management program.
Medical Director	Provides oversight for the Utilization Management Committee along with the Utilization Management Division Director.
Director	Reviews and responds to recommendations from the Utilization Management Committee.
Attachments:	