

Effective Date: 3/8/2007
Revised Date: 2/25/08
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Authorization for Ongoing Outpatient Services

Authorizing Source: CFR 438.210; MHD Contract 2007-09; Provider Contract 2007-09

Cancels:

See Also:

Responsible Staff: Quality Manager

Approved by: Executive Director

Date: 3/31/08

Signature:

POLICY #1505.00

SUBJECT: AUTHORIZATION FOR ONGOING OUTPATIENT SERVICES

PURPOSE

To outline and ensure consistent application of the North Sound Mental Health Administration's (NSMHA) authorization process.

POLICY

NSMHA will authorize an assessment for all persons calling the ACCESS Line who are financially eligible as defined in the Clinical Eligibility and Care Standards (CECS). The consumer will be referred to a NSMHA provider agency for a face-to-face clinical assessment by a mental health professional (MHP). Consumers who are in crisis are referred to the Integrated Crisis Response System (ICRS) as appropriate to the situation. Expedited assessments and authorizations will be available when it is medically necessary. Once the assessment is completed, the decision whether to authorize ongoing outpatient services will be determined by NSMHA.

Role of Provider (each NSMHA contracted provider will):

1. Comply with NSMHA mechanisms to ensure consistent application of review criteria for authorization decisions, including consultation with NSMHA when appropriate.
2. Identify, define, and specify the amount, duration, and scope of each service the consumer will receive in collaboration with the consumer.
3. Provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
4. Ensure services are provided in accordance with NSMHA's level of care guidelines as medically necessary and are not arbitrarily denied or reduced, (for example, the amount, duration, or scope of a required service) based solely upon diagnosis, type of mental illness, or the consumer's mental health condition.
5. Submit requests and supporting documentation in a timely manner so that NSMHA may comply with specified timeframes for decisions as required by federal and state standards.

Role of NSMHA:

1. Ensure consistent application of review criteria for authorization decisions and not arbitrarily deny a service authorization request.
2. Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
3. Not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or mental health condition of the consumer.
4. Ensure that authorization of a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the consumer's condition or disease.

5. NSMHA will comply with specified timeframes for decisions as required by federal and state standards.
6. NSMHA will provide for the following decisions and notices*:

- a. **Standard authorization decisions.** For standard authorization decisions, provide notice as expeditiously as the consumer's health condition requires and within state-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the consumer or the provider requests extension. An extension may also be obtained if NSMHA justifies (to the Washington State Mental Health Division upon request) a need for additional information and how the extension is in the consumer's interest.
- b. **Expedited authorization decisions.** For cases in which a provider indicates, or NSMHA or its designee determines, that following the standard timeframe could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function, NSMHA must make an expedited authorization decision and provide notice as expeditiously as the consumer's health condition requires and no later than three (3) working days after receipt of the request for service. NSMHA may extend the three (3) working days time period by up to 14 calendar days if the consumer requests an extension. An extension may also be obtained if NSMHA justifies (to the Washington State Mental Health Division upon request) a need for additional information and how the extension is in the consumer's interest.

* When calculating the number of days from the request for service, the first day is the day after the request for service. For example, the request for service is received on January 14th a standard decision must occur by or on January 28th. For a request that comes in on a Thursday and is identified as expedited, the assessment and authorization decision must be completed by the end of the following Tuesday.

7. NSMHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required by federal and state standards. NSMHA and its contractors will consider what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the Washington State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. NSMHA, in accordance with these regulations, is responsible for covering services related to the following:
 - a. The prevention, diagnosis, and treatment of health impairments.
 - b. The ability to achieve age-appropriate growth and development.
 - c. The ability to attain, maintain, or regain functional capacity.
8. NSMHA will ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any consumer.

PROCEDURE

Provider Request for Authorization

1. ACCESS clinicians will screen callers requesting service to determine the caller's safety concerns, mental health concerns and financial eligibility. ACCESS clinicians will determine whether following the standard timeframe could seriously jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum function so that, if appropriate, an expedited assessment can be authorized and scheduled.

2. Through ACCESS, all callers who meet financial eligibility, as defined in the CECS, are assisted to make an assessment appointment at the consumer's preferred provider agency. This appointment will be offered to occur within 14 calendar days of the request for services or for expedited assessment to occur as soon as is medically necessary and within three (3) working days to determine clinical eligibility and the appropriate level of care.
3. Authorization requests and any accompanying documentation are completed and sent to NSMHA within 14 calendar days of the initial request for service or within three (3) working days for expedited authorizations.
 - a. If seeking information presents a barrier to service the item is left blank and the reason documented in the clinical chart.
 - b. If the assessing clinician cannot complete the initial assessment within the first 14 calendar days, the consumer or the assessment clinician may request an extension of up to an additional 14 calendar days.
4. The agency clinician conducting the face-to-face assessment will make an initial recommendation as to whether the person being assessed meets Access to Care Standards (ACS) and medical necessity criteria (as defined in the CECS).
5. If the provider believes ACS and medical necessity are met, they will transmit a completed electronic request for authorization including a full five-axis classification, eligibility criteria, and identified Level of Care to NSMHA. If necessary, NSMHA staff will request additional clinical information to justify the authorization. Each contracted provider will identify a contact person to whom requests for additional information can be made.
6. For expedited authorizations, phone notification will be made to NSMHA (360-416-7013) to alert them to the need for immediate review. Phone notification shall be followed by faxing the authorization request and assessment to NSMHA (360-416-7017) for review. An electronic authorization request shall also be sent once NSMHA provides verbal authorization.
7. All persons who meet the financial criteria, ACS and medical necessity criteria are authorized by NSMHA within one business day of the receipt of the authorization request. NSMHA will notify the consumer and provider of all authorizations and their benefits. (Please note: Not all services are authorized initially. See the Utilization Guidelines, 1565.01 and 1565.02, for services which must be approved by NSMHA prior to provision of the service). If authorized, the person is accepted into services and appropriate appointments are made.
8. If NSMHA reviewers deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested, they will notify the requesting provider and give the consumer written notice in sufficient time to ensure that state-established timeframes are met.

Provider Request for Adverse Determination

1. If the provider believes ACS and medical necessity are not met, they will send the intake assessment form, ACCESS call sheet and any other available documentation or medical records reviewed in the assessment process to NSMHA staff with the completed NSMHA Review Request form within 14 calendar days (standard) or within three (3) working days (expedited) from the initial request for service.
2. For requests submitted on the last day of the specified timeframe (i.e. the 14th, 3rd or 28th day), phone notification will be made to NSMHA (360-416-7013) to alert them to the need for immediate review.
3. NSMHA staff will review the documentation and determine whether to authorize services.
 - a. If services are authorized, NSMHA staff will notify the consumer and provider of the decision to authorize services. The consumer will be notified of their benefit package.

- b. If no services are authorized, NSMHA will notify the requesting provider and give the consumer written notice in sufficient time to ensure that state-established timeframes are met.

Extensions

Extensions are defined as the submission of a review request by a provider to NSMHA or an authorization decision by NSMHA past the first 14 calendar days from the initial request for service. Extensions shall be utilized only in rare circumstances and must be of benefit to the consumer. When an extension is utilized, the provider agency must document a rationale for the extension in its authorization or adverse determination request to NSMHA. NSMHA will monitor the use and pattern of extensions and apply corrective action where necessary.

Residential Facility Authorizations:

Discharges from Western State Hospital and Community Hospitals: Residential service providers will notify ACCESS when they schedule an assessment appointment for a consumer to be admitted to their facility from the hospital. If this is more than 14 days ahead of when the person is ready for discharge, ACCESS will retain the information in a pending file. This application will be considered incomplete until the consumer is fully ready to be discharged from hospitals at which time the provider will notify ACCESS and the time requirements will begin. The standard access procedures and timelines will be followed from the date of assessment.

Change in Mental Health Coverage

For consumers who become NSMHA-eligible while already in treatment with a provider agency, a current diagnostic justification must be present in the clinical record. The current assessment and treatment plan must meet or be enhanced to meet Mental Health Division (MHD) and NSMHA standards.

Authorization for services will be submitted to NSMHA within 14 days of the time the provider becomes aware of the change in payer. Because authorization periods are for one year, only one annual request for authorization is required to be submitted, regardless if the consumer gains or loses financial eligibility. Providers are responsible for assuring that the appropriate funding source is charged for services depending upon the consumer's financial eligibility.

Consumer Withdrawal of Request for Service

If a consumer requests an assessment for services and during or at the completion of the assessment appointment(s) the consumer indicates they no longer wish to receive services, the consumer will be asked to sign a document to that effect, and documentation of their withdrawal of request will be kept in their record.

ATTACHMENTS

None