__ Avante Health X Avante Behavioral Health __ PSY-Care

POLICIES & PROCEDURES
UM 11

Subject: UM Subcommitee

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Department: Utilization Management	Last Rev. Date: May 1, 2013	

Approved by:	Title:	Date:

AVANTE BEHAVIORAL HEALTH PLAN (ABHP)

Referral and Authorization Process

Purpose

The Medical Director and the Utilization Management Subcommittee oversee the development and implementation of an effective referral and authorization process. This process and structure involves the UM Program's methods for reviewing and authorizing (or denying) requested healthcare services.

Scope

The UM Administrator, a licensed behavioral healthcare professional, works in conjunction with the Plan's Medical Director and the UM Subcommittee to assign authorizations appropriately. All requests for authorization of services will be processed according to ABHP approved policies and procedures.

Policy

The UM staff will follow ABHP's approved process for reviewing and authorizing (or denying) requested services. The authorization/denial determinations will be based on medical necessity and the level of urgency and will reflect appropriate application of ABHP's approved practice guidelines and criteria. The Medical Director will review and sign every denial based on medical necessity. Information will be clearly documented and appropriately available for review.

Medical Necessity: Except where any applicable law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Procedure

ABHP's Medical Director and UM Subcommittee will determine how closely managed the referral process will be in regard to authorization of particular services. Similarly, if the UM Subcommittee determines that certain services will be automatically authorized, a list of those services and criteria will be made available to the UM staff and providers.

1. The utilization management team of psychiatrist, psychologist, licensed staff, and support staff carry out the responsibilities designated for their level of expertise. Qualified health professionals' asses the clinical information, which is utilized in making utilization management decisions. Appropriately licensed health professional supervise all review decisions. A SENIOR behavioral health care practitioner is actively involved in implementing the UM program. Staff who are not qualified health professionals must, under the supervision of appropriately licensed health professionals, collect data for preauthorization and concurrent review. They must also have the authority to approve (but not to deny) services for which there are explicit criteria. UM Decision making will included but not limited to the following functions:
    a. Prospective Review
    b. Concurrent Review
    c. Inpatient Review
    d. Discharge Planning
    e. Retrospective Review
    f. Appeals
    g. Case Management

2. Referrals and requests for authorization are sent by providers to ABHP UM Department by mail, fax, email, or telephone.

3. ABHP staff dates the request when it is received, when it is sent to the reviewer, when the reviewer returns the treatment plan, and finally when notification of decision for approval or denial of care via the treatment plan is given to the provider.

4. Member eligibility and benefits are checked.

5. Emergent/urgent requests are processed immediately.

6. The request is checked for complete information such as:

    - Member Name
    - Other Insurance
    - Member ID #
    - Requesting Provider
    - Referral Provider
    - Services which are required as a result of an accident (are specified as such and the location of the accident is noted: work, home, auto,or other)
    - Diagnosis (DSM-5)
    - Clinical History/Findings which justify the requested procedure
    - Attempted treatment, other consults
    - Medications
    - Requested care, procedure, or test
    - Description of service (inpatient, outpatient, or office)
    - Estimated length of stay (for inpatient requests) or treatment (for outpatient requests)

7. If information is incomplete, the request is held and the necessary data is obtained from the treating provider. If the Plan requests additional medical information from providers, it shall request only the information reasonably necessary to make the determination.

8. The member's file information then is accessed if it is available.

9. The request is submitted to the UM Administrator and/or Medical Director, who will be responsible for completing the authorization process.

10. Complex cases are referred to the Medical Director and/or Utilization Management Subcommittee. Board-certified psychiatrists from appropriate specialty areas may assist in making determinations of medical appropriateness.

11. Only the Medical Director may make determinations for the denial of requests based on medical appropriateness.

12. Providers have access to all criteria used in the decision making process.

13. The criteria and clinical practice guidelines used in the determination of medical appropriateness of services will be clearly documented. This information will be available via the website, upon request, to participating providers, ABHP members, and the public. Disclosure of UM criteria to the public will be accompanied by the following notice: "The materials provided are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

14. Practitioners may obtain UM criteria by contacting Avante at (559) 261-9060 or in writing at:

    Avante Health
    1111 East Herndon Ave #308
    Fresno, CA 93720

15. Avante will disclose upon request utilization management policies, procedures, and criteria used to authorize, modify, or deny healthcare services to the public, members or person designated by members by having submit requests to the address listed above.

16. ABHP will consider at least the following factors in addition to Clinical Guidelines when applying criteria to a given case or individual:

    - Age
    - Comorbidities
    - Complications
    - Progress of Treatment
    - Psychosocial situation
    - Home Environment, when applicable
    - Characteristics of the local delivery system that are available to a particular patient
    - Internal clinical guidance
    - Secondary set of UM criteria

17. All authorization requests are followed by notification to the providers of the determination.

18. Approved requests will include an authorization number for the specific services authorized.

19. Any denials for services or payment will be handled per ABHP's policy and procedure "Denial and Appeal Process".

20. ABHP will honor requests for specific contracted providers as well as specific provider disciplines.

21. Requests for excluded mental health services that are covered by the member's full service health plan will be referred to the member's full service health plan.

22. A member, if he or she chooses, does not have to give any information regarding their presenting symptoms and may be referred directly to a clinician or choose which clinician he or she wishes to see.

23. All written communications with the provider shall be clear and concise, provide the clinical reasons in matters of medical necessity, and include the name and phone number of the Medical Director in each provider communication.

24. ABHP makes available to practitioners an appropriate reviewer (psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist) to discuss by telephone determinations based on clinical appropriateness.

25. For denials, ABHP sends written notification to members and practitioners, as appropriate, of the reason for each denial, including the specific utilization review criteria or benefits provisions used in the determination.

26. ABHP includes information about the appeal process in all denial notifications.

27. The Plan reviews and updates protocols on parity conditions, when appropriate, on a regular basis. CA Health and Safety Code section 1363.5(b)

Time Frames

ABHP will meet all regulatory and contracted health plan standards for the amount of time allowed to process referral/authorization requests. ABHP will make authorization decisions in a timely manner and accommodate the urgency of individual situations.

1. Emergent referrals and authorization requests will be processed immediately. The UM Administrator will contact the Medical Director or physician designee for

assistance as necessary. The member and provider are notified by phone; confirmation is sent in writing.

2. Urgent referrals and authorization requests are processed within one (1) calendar day. The UM Administrator will contact the Medical Director or physician designee for assistance as necessary. The member and provider are notified by phone.

    a. A member with urgent needs is offered an appointment within forty-eight (48) hours.

    b. Routine referrals and authorization requests are processed within five (5) calendar days.
    c. A member requesting a routine office visit is offered an appointment within fourteen (14) calendar days. The member and provider are notified by phone or by mail.

3. Requests for excluded mental health services, which are covered by the member's full service health plan, will be referred to the member's full service health plan in a timely manner.

4. Providers are notified of denials within twenty-four (24) hours of the Plan's decision.