Section 4

UTILIZATION MANAGEMENT PROCEDURES

Utilization management is the responsibility of the ValueOptions Clinical Care Managers (CCM) who conduct clinical reviews and care management for all levels of care. The frequency of review varies with the intensity of the level of care being provided and the clinical needs of the member. All care provided to members must be authorized by ValueOptions. Member consent is not required for provider participation in utilization management activities.

ValueOptions CCMs are responsible for the following functions:

- To conduct reviews with treatment providers to verify medical necessity based on BHO treatment criteria at point of access, for continuing care, and aftercare.
- To ensure that the evaluation of the member includes pertinent psychosocial, medical and psychiatric/mental health information to support the diagnosis and impairments determined by the provider.
- To ensure that service plans are strengths-based, address the current problems represented by the diagnosis and impairments identified by the provider, are coordinated with other service delivery persons or agencies, and are consistent with the BHO's clinical criteria.
- To ensure that level-of-care and treatment decisions are based on medical appropriateness and necessity, as described in the clinical criteria, and are designed to achieve desired member outcomes within an optimal time frame.
- To ensure that discharge planning begins at admission, that the planning involves the member, significant others and other representatives who will ensure implementation of the discharge plan, that clear and specific criteria for discharging members from treatment are established at the outset of treatment, that the plan is realistic and attainable, and that it is both understood by and agreed to by the member and family/significant others as appropriate.
- To provide consultation to treatment team members when needs of members are complex.

WHEN DOES THE CCM CONDUCT CARE MANAGEMENT FUNCTIONS?

- When the TeleConnect/IVR system or ProviderConnect directs the provider-user to call the CCM.
- When a provider contacts the CCM for initial or continuing authorization.
- When there is a need to change the level of care being provided.
- When quality data related to any aspect of member care indicates the need for provider involvement to clarify or take action on identified patterns/trends.

OUTPATIENT CARE INITIAL AUTHORIZATION:

1. Providers should complete an initial evaluation then obtain authorization for outpatient care via ProviderConnect or TeleConnect (IVR) within 30 days after the initial evaluation.
2. Initial authorization includes psychotherapy and the evaluation session. See the BHO specific addendum for more information.
3. The initial authorization will indicate a specific provider(s) and service class, which includes the initial evaluation, case management (if included), individual, family and group psychotherapy.
4. Family therapy is conducted for the treatment of the identified member's covered diagnosis only and billed under this individual's Medicaid. Separate billing for other family members who participate in the family therapy sessions is not allowed.
5. Medication management does not require authorization.
6. The Colorado Client Assessment Record (required by Colorado Department of Health and Human Services) shall be submitted promptly after authorization has been obtained. See CCAR, Section 12, for a copy of these forms. Providers can fill out CCAR forms on the website at http://www.chneforms.com/ccar/login.cfm. Even if care is authorized, **claims could be held for non-submission of a valid CCAR form**.

CONTINUED AUTHORIZATION:

1. If further care is requested and determined to be clinically indicated, subsequent authorization will be made through ProviderConnect or TeleConnect/IVR.
2. If the treatment plan does not meet clinical criteria, a CCM will address the relevant issues with the provider and refer the case for review.
3. Routine outpatient care will not be authorized on a retrospective basis, except in cases of retroactive Medicaid eligibility.

INPATIENT AND PARTIAL HOSPITAL PRIOR AUTHORIZATION:

Prior authorization is required for all inpatient and partial hospital admissions. ValueOptions may require an independent assessment by a CMHC Crisis Evaluator prior to admission. In most cases, the CCM will consult with the local CMHC for availability of hospital diversion services prior to authorizing inpatient care. Providers must direct members to a ValueOptions contracted facility to ensure eligibility for hospitalization benefits. The Colorado Client Assessment Record (required by Colorado Department of Health and Human Services) shall be submitted promptly after authorization is obtained. See CCAR Section 12, for more information about the CCCAR. To fill out a CCAR our website, visit http://www.chneforms.com/ccar/login.cfm. Even if care is authorized, **claims could be held for non-submission of a valid CCAR form**.

CONTINUED AUTHORIZATION:

1. Pre-authorization of continuing inpatient and partial hospital care requires a telephonic or on-site review between the provider and ValueOptions CCM.
2. ValueOptions requires active collaboration with regional CMHC care coordinators in discharge planning.

3. To evaluate the inpatient or partial hospital request, the CCM will require detailed information concerning the member's need for continuing care (i.e., treatment and discharge plans, current condition, and any additional services). It is the responsibility of the hospital's designated case manager to call the Service Center for review and continued authorization prior to expiration of the current authorization. Late requests may not be retroactively authorized.

HOSPITAL PROFESSIONAL CHARGES:
Some facility contracts are all-inclusive. Professional charges may be included in contract rates. It is the responsibility of the facility to negotiate reimbursement with the professional staff.

EMERGENCY SERVICES:

1. Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.
2. Emergency services do not require prior authorization.
3. Documentation must accompany claims for emergency services in order to support covered diagnosis.

OTHER LEVELS OF CARE, INCLUDING RESIDENTIAL, DAY TREATMENT, AND ACUTE TREATMENT UNIT

Authorization is required through a ValueOptions CCM before a member can be admitted to other levels of care (based on demonstration of medical necessity, demographics, and verification of eligibility). An independent evaluation may be required prior to authorization for higher levels of care. Contact the ValueOptions Access to Care Line to determine if an independent evaluation is required and to obtain the authorization process for specific levels of care.

AUTHORIZATION WHEN LEVEL OF CARE CHANGES

1. Authorization of care does not extend from one level of care to another. CCMs must be notified immediately when a member is discharged from any level of care.
2. Authorization for treatment at a new level will be based on the current treatment plan and continuity-of-care concerns.
3. A new authorization will be required with any change in the level of care.
4. Any unused portions of prior-to-admission outpatient authorizations are null and void once an inpatient/partial hospital/alternative level of care case is opened.

ELECTROCONVULSIVE THERAPY (ECT)

All inpatient and outpatient ECT requires pre-authorization. ECT requests must be reviewed by the BHO Medical Director.

PSYCHOLOGICAL TESTING (ALL TESTING REQUIRES PRE-AUTHORIZATION)

The use of psychological testing can be very beneficial when it provides information relevant to the treatment of a psychiatric condition in a timely manner. Rather than being considered a

routine procedure in an individual's treatment, testing should be requested only when other interventions have not been successful in providing sufficient information with which to develop an appropriate treatment plan.

When psychological testing is necessary, it should be requested in order to address specific questions which may be useful in diagnostic clarification and subsequent treatment planning. Specific testing procedures selected by the psychologist should demonstrate a focused approach toward addressing the referral questions. "Standard batteries" are discouraged. Educational testing (e.g., learning disabilities assessments), vocational testing, and testing conducted in order to rule out medical conditions (e.g., many neuropsychological assessments) are excluded benefits and will not be authorized. Pre-authorization for up to one hour of screening may be obtained by calling 1-800-804-5008. All testing beyond one hour's screening requires preauthorization based on submission of a Psychological Evaluation Request Form prior to testing. If you are both the treating therapist and a licensed psychologist, complete both sides of the form and mail or fax to ValueOptions' Clinical Management Department. If you are the treating therapist, but not a licensed psychologist, please take these steps to ensure a correctly completed form:

- Call the ValueOptions Access to Care line for assistance with referral to a network psychologist with the appropriate expertise.
- Complete Page 1 of the Request Form and fax/mail to ValueOptions. After the evaluation is assigned to a provider, the testing psychologist may request a phone consultation to insure that he/she has as much clinical information as possible and understands your questions.
- The psychologist must complete Page 2 and mail or fax the form to ValueOptions for authorization:

ValueOptions Colorado
7150 Campus Drive, Suite 300
Colorado Springs, CO 80920
FAX: (719) 538-1439

***NOTE:** Authorization on inpatient psychological testing can be expedited by calling 1-800-804-5008. Most contracts include all professional fees. For reimbursement, all psychological testing must be preauthorized.

GUIDELINES:

- One unit of testing equals one hour.
- Testing is only authorized for face-to-face administration of testing procedures by a psychologist or psychometrician working under the supervision of a psychologist (i.e., chart reviews and testing feedback sessions are not to be authorized as a psychological testing procedure).
- The use of self-administered objective inventories is encouraged prior to requesting more extensive testing. One hour can be authorized by ValueOptions for such screenings. The following is a list of the most frequently requested inventories:

MMPI-2 Minnesota Multiphasic Personality Inventory-2 (Adult)
MMPI-A Minnesota Multiphasic Personality Inventory-Adolescent
MCMI-II Millon Clinical Multiaxial Inventory-II (Adult)
MAPI Millon Adolescent Personality Inventory
MACI Millon Adolescent Clinical Inventory

PIC Personality Inventory for Children

- When such inventories do not provide sufficient information, additional testing may be warranted. Authorization for **personality assessments** vary depending upon the nature of the questions being asked and the specific tests being proposed to address those questions. The following tests are the most often utilized for personality assessment and the standard authorization allowed for each procedure is:

  Rorschach Projective Technique 1.5 hours
  Apperception Technique (TAT, CAT, or Roberts) 1.0 hours
  Projective Drawings (DAP or H-T-P or Kinetic Family Drawing) .5 hours
  Beck Depression Inventory .5 hours
  Reynolds Depression Scales (Child, Adolescent, or Adult) .5 hours
  Sentence Completion or Incomplete Sentences Procedures .5 hours
  Bender Visual-Motor Gestalt Test .5 hours

- The use of intellectual assessments can be authorized only if they are being used to clarify a psychiatric diagnosis. Appropriate uses would be for assessment of psychosis, neuropsychological screening, and, in some instances, the assessment of attention deficit disorders. The most often requested procedures for intellectual assessments are the Wechsler Scales:

  WPPSI-R (preschool) 1.5 hours
  WISC-IV (children & adolescents) 1.5 hours
  WAIS-III or WAIS-IV (adults) 1.5 hours

- **ATTENTION DEFICIT DISORDER ASSESSMENTS:** There is wide variation between practitioners in conducting these assessments. Focused evaluations can generally accomplish this assessment in one to three hours. Full, comprehensive, neuropsychological evaluations, which are often requested (sometimes from six to twelve hours) are not medically necessary to identify and diagnose ADD or ADHD. The following are the most commonly used procedures for ADD assessments.

  Rating scales (Parent's, Teacher's, Connors scales, etc.) .5 hours
  CBCL (Child Behavior Checklist) .5 hours
  Gordon Diagnostic System 1.0 hours
  TOVA (Test of Variables of Attention) 1.0 hours
  WISC-IV (Wechsler Intelligence Scale for Children – IV) 1.5 hours

- **NEUROPSYCHOLOGICAL ASSESSMENTS:** Neuropsychological assessments will be authorized for individuals receiving mental health services only when treatment planning considerations warrant such an evaluation. Generally, neuropsychological evaluations can be completed within six hours.

GENERAL MEDICAL RECORD REQUIREMENTS (SEE SECTION 19 OF THIS MANUAL FOR DOCUMENTATION REQUIREMENTS)

The State of Colorado requires the completion of the Colorado Client Assessment Record (CCAR). Additionally, ValueOptions has medical record requirements for members receiving services at any level of intensity.

1. CCAR: Form must be completed promptly after initial authorization is received, at discharge and once annually if the member is in treatment for 12 months or longer. Please submit the CCAR to ValueOptions promptly upon completion. (See Section 12 for instructions.) Even if care is authorized, **claims could be held for non-submission of a valid CCAR form**.
2. Coordination of Care: All providers are expected to coordinate care with any client's primary care physician and with other treatment providers. Coordination of care is required and should be documented. A release of information is required for the coordination of care with other providers.
3. Missed Appointments: Providers are expected to contact members who unexpectedly miss an appointment within 24 hours of the missed appointment. The urgency of the contact is determined by the provider's assessment of risk potential related to the missed appointment. Actions are to be documented in the member's medical record.
4. Medical Record and Treatment Plan:
    a. All documentation requirements in Section 19 must be contained in the member's medical record. Additionally, all member medical records must contain a comprehensive biopsychosocial assessment, measurable treatment goals, signed progress notes, and a discharge plan.The treatment plan should indicate involvement of a member's family/significant others when clinically indicated. If not clinically indicated, this should be noted as a part of the plan. Medical and psychological treatment documentation and progress notes must be current, dated and signed, and treatment plans must be updated regularly.
    b. The provider initiating treatment must document an initial treatment plan that describes the specific target problems or symptoms and strengths, as well as the diagnosis, planned interventions at the level of care proposed and clear, specific criteria for discharging the member from treatment that are agreed upon by member and provider. Discharge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan. The treatment plan must be signed by the member or the member's guardian. If the member refuses to sign, this too should be documented in the record.
    c. Progress notes must reflect that treatment provided to the member is tied to the goals of the treatment plan.
    d. We require thorough documentation of regular communication with other providers, including physical health providers, and an integrated treatment plan.
    e. Medical records are subject to quality of care and financial audits. Client consent is not necessary. Providers asked to submit records for audit purposes will be reimbursed according to policy upon receipt of copies and an invoice.

5. Advanced Directives

It is the policy of ValueOptions to inform members of their right to make medical decisions in compliance with the Patient Self-Determination Act ((s. 4206 s. 4751;Pub L No. 101-508) and the Colorado Medical Treatment Decision Act (CRS 15.18.103.) and to assist them in using this right. Notification is made through a description of The Act in the member handbook.

a. If a member requests additional information on The Act from the provider, the member can be referred to the BHO Office of Member and Family Affairs, the Member Handbook, or the BHO website.
b. For help writing an Advanced Directive, refer the member to her/his PCP or to the Colorado Bar Association. In Colorado, Advanced Directives, as defined in the Patient Self-Determination Act, apply to medical/surgical procedures, not psychiatric conditions.
c. Providers are encouraged to assist members to develop crisis plans that define the member's wishes in time of psychiatric crisis.
d. Providers are required to ask members if they have an Advanced Directive and are encouraged to ask if they would like a copy placed in their mental health record. Providers must document in a prominent part of the individual's current medical record whether or not the individual has executed an advanced directive. If the member is incapacitated at the time of admission, the provider shall ask the family or significant other if the member has an Advanced Directive and shall give the family information about advanced directives. At such time as the member is able to understand the question, the provider must again ask if the member has an Advanced Directive and, if so, document that in the medical record.
e. A provider may not condition a member's care or treatment on whether or not he/she has executed an advanced directive.
f. Providers must inform members how to report a grievance to the appropriate state agency, if an advanced directive is not followed.