DAVIS BEHAVIORAL HEALTH
Community • Commitment • Change

SERVICE AUTHORIZATION

Policies & Procedures

Section: Clinical Policies

Pages: 7

Subject: Service Authorization Policy

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POLICY

Services provided by Davis Behavioral Health are prioritized as to population and scope according to statutory and contractual requirements. The delivery of services by an appropriate provider is prioritized as to 1) employee providers, 2) subcontracted providers, and 3) alternative(non-panel) providers, respectively. Requests for the delivery of services are subject to authorization as specified in the following procedures.

PROCEDURES

A. Authorization for service delivery – employee providers

1. Initial Requests for Service (internal intake system) – non-client

a. The service authorization process relative to employee providers is initiated by a formal request for service (RFS). Requests for service are received by the DBH clinical support staff. Requests clearly stated to be for routine service are scheduled for initial intake and assessment within 15 days. Those requests for emergent services are immediately forwarded to the crisis worker who will evaluate for an initial determination of level of service need (i.e., emergency, urgent, or non-urgent). For urgent and non-urgent determinations, the crisis team will offer and schedule, as available, an initial face-to-face or telehealth appointment for clinical assessment within five and fifteen working days respectively.

b. Requests for emergency (crisis) services will be forwarded immediately to DBH's Crisis Team Crisis staff will respond to the request for emergency services within 30 minutes and determine the level of service need (i.e., emergency, urgent, non-urgent).

c. Upon determination of a need for emergency services, a crisis team member will facilitate an initial face-to-face or telehealth contact with

the prospective client within one hour following the crisis screening.

d. As indicated above, the request for service is followed by an initial face-to-face clinical assessment to determine the specific services needed. The completion of the assessment and documentation of service need constitutes a service authorization. Once services are assessed and authorized, an individualized treatment plan is formulated to address the amount, duration, and scope of service delivery particular to the client. Amount, duration and scope of service are authorized based on clinical need and benefit coverage. The client is then scheduled for follow-up service appointments as expeditiously as the client's health condition may require, and capacity allows.

e. Services requested but not available within the scope of DBH's covered services are not the obligation of DBH and cannot be authorized.

f. Failure to provide the first face-to-face service within the time frames specified above for emergency, urgent, and non-urgent service determinations will constitute an Action (to include a Notice of Adverse Benefit to be provided at the time it is determined the time frame will not be met) only when:

    i. The reason is due to DBH's limitations; and

    ii. The client is dissatisfied with waiting beyond the required time frame.

g. Any decision to deny a *service authorization request* or to authorize a *service* in an amount, duration, or scope that is less than requested, including the type or level of service (with the exception of services that are not "covered" under the Utah Department of Health Contract constitutes an Action and requires DBH to provide a written Notice of Adverse Beneft to the client.

h. If the DBH terminates, suspends, or reduces previously authorized services, and the client informs DBH that he or she disagrees with the change in his or her treatment plan, DBH will mail a notice of adverse benefit to the client.

2. Additional service requests – existing client

a. Requests by an existing client for additional services not previously authorized (i.e., ECT, residential treatment, etc.) may be made orally or in writing. These requests will first be evaluated by the client's current treatment coordinator to determine medical necessity.

b. If considered medically necessary, and within the standard benefit offered by DBH, the new treatment coordinator will amend the client's treatment plan to authorize and include the requested service as expeditiously as the health condition of the client requires.

c. If the service request/need is one for which DBH must contract, the treatment team will refer to DBH's compliance and contracting department to authorize and obtain necessary services.

    i. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports.
        - These services and supports are designed to help clients have access to the benefits of community living, to achieve person centered goals via shared decision making, and help clients be able to live and work in the setting of their choice.

d. If the requested service is not within the scope of the treatment coordinator's practice and/or licensure, the request will be forwarded to appropriate clinical and/or administrative staff with clinical expertise and credentialing necessary to make a determination of medical necessity and provide authorization for service delivery.

e. If authorization is denied, DBH will provide a written Notice of Adverse Benefit to the client. If approved, the client will be notified in writing, and service delivery will be coordinated by the authorizing clinician or designee.

f. Any decision to deny a service authorization or to authorize a service in an amount, duration, or scope that is less than requested will be made by appropriately credentialed staff having clinical expertise in treating the client's diagnosed condition.

3. A continuation of service delivery beyond any limits that may be specified must be re-authorized following the procedures outlined above, following a written request for continued authorization.
4. A "second opinion" related to the authorization of services, initial assessment, diagnosis, and/or available treatment options will be provided upon request at no cost to the enrollee.
5. Standard or expedited authorizations are provided within the same parameters as those identified below for subcontractors.

B. AUTHORIZATION FOR SERVICE DELIVERY – SUBCONTRACTED PROVIDERS

1. Requests for authorization and service delivery by a subcontracted provider must be submitted to the Off Panel Coordinator either verbally or in writing. Prior to the authorization of service delivery by a subcontracted provider, an initial clinical assessment (or reassessment for existing clients) must be completed by the requesting provider who must forward the evaluation and a treatment plan to the Off Panel Coordinator. The Off Panel

Coordinator will present the documentation to the Compliance Officer, or designee, who must be a licensed mental health provider, for review and authorization. Individuals who refuse assessment or reassessment will be denied authorization for service provision by the subcontracted provider.

2. DBH will also mail the client a written Notice of Adverse Benefit at the time of the action affecting a claim if the denial reason is that: (1) the service was not authorized by DBH, as the client could be liable for payment if the client gave advance written consent that he or she would pay for the specific service; (2) the client requested continued benefits (services) during an appeal or State fair hearing and the appeal or State fair hearing decision was adverse to the client; or (3) the client was not eligible for Medicaid when the services were provided.

3. The Compliance Officer or designee will review the assessment in consultation with the assessing clinician, consult with the requested provider if necessary, and determine the appropriateness of an alternative provider based upon the following review criteria:

    a. Type of service requested;
    b. Amount, duration, and scope of service requested;
    c. Credentials, expertise, and capacity of Center staff;
    d. Credentials, expertise, and capacity of requested provider;
    e. History of previous treatment;
    f. Extenuating circumstances.

4. DBH will make a service authorization determination and provide notice of the decision to the subcontractor and the client as expeditiously as the client's condition may require, but no later than 14 calendar days from the date of receipt of the subcontractor's request for service authorization. This will be tracked on the off-panel request form.

5. DBH may extend the time frame for making a service authorization decision by up to 14 calendar days if the client or subcontractor requests an extension, or upon request by the Department of Health and Human Services (DHHS) and DBH justifies that there is a need for additional information and that the extension is in the best interest of the client.

6. If the time frame for making a service authorization decision is extended, DBH will:

    a. Give the client written notice of the reason for the decision.

    b. Inform the client of his or her right to file a Grievance, and how to do so, if the client disagrees with the decision, and

    c. Carry out the service authorization determination as expeditiously as may be required by the client's health condition, however, no later than the date the extension expires.

7. The above time frames will apply unless the client's health or safety (as indicated by the subcontractor or determined by DBH) requires an expedited decision, in which case the assessment and authorization must be accomplished and notice provided as expeditiously as the client's health condition requires, but no later than 72 hours from receipt of the request for service by the subcontractor.

8. The time frame for an expedited decision may be extended by up to 14 calendar days if the client or subcontractor requests an extension, or upon request by the DHHS and DBH justifies that there is a need for additional information and that the extension is in the best interest of the client.

9. If DBH extends the timeframe for standard or expedited authorization decisions, it must:

    a. Give the member written notice of the reason for the extension (no later than the date the authorization timeframe expires).
    b. Inform the member of the right to file a grievance if he or she disagrees with that decision.
    c. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

10. Failure to reach a service authorization decision within the time frames as indicated above will constitute an Action and require DBH to provide a Notice of Adverse Benefit to the client (written) as well as provide notice to the subcontractor (oral or written) by or on the date the time frame expires.

11. Any decision to deny a service authorization or to authorize a service in an amount, duration, or scope that is less than requested will be made by appropriately credentialed staff having clinical expertise in treating the client's diagnosed condition.

12. Any decision to deny a *service authorization request* (not a request for services from a specific provider), or to authorize a *service* in an amount, duration, or scope that is less than requested, including the type or level of service (with the exception of services that are not "covered" under the DHCF contract), constitutes an Action and requires DBH to provide a Notice of Adverse Benefit to the client (written) as well as provide notice to the subcontractor (orally or in writing).

13. A continuation of service delivery beyond any limits that may be specified must be re-authorized following the procedures outlined above, following a written request for continued authorization.

14. A "second opinion" related to the authorization of services, initial assessment, diagnosis, and/or available treatment options will be provided upon request.

C. AUTHORIZATION FOR SERVICE DELIVERY - NON-SUBCONTRACTED OR NON-PANEL (ALTERNATIVE) PROVIDERS

1. Requests for authorization and service delivery by a non-subcontracted or non-panel provider (alternative provider) must be made to DBH's UCM either verbally or in writing, prior to the authorization of service delivery by an alternative provider, an initial clinical assessment (or reassessment for existing clients) must be completed as specified in section A, 1, d above, to determine the relevant treatment issues and service need. Individuals who refuse assessment will be denied authorization for service provision by an alternative provider.

2. Within a reasonable period of time following the clinical assessment, but not to exceed 30 days, the Compliance Officer or designee will review the assessment in consultation with the assessing clinician, consult with the requested provider if necessary, and determine the appropriateness of an alternative provider based upon the Levels of Care guide.

3. Clients will be notified either orally or in writing as to the determination for service delivery by an alternative provider and such determination will be documented in the clinical record using an approved form.

4. Clients denied a request to see an alternative provider shall be contacted directly to discuss options and alternatives. Clients approved for delivery of services by an alternative provider will be subject to that provider's service delivery schedule in which case performance standards relative to initial face-to-face contact shall not apply.

5. If approved, the alternative provider will be required to enter into a written subcontract with DBH and must meet all established guidelines for subcontractors as set by the local authority and as specified by Center contract with the Division of Health Care Financing.

6. Items 4 through 13 of Section B pertaining to subcontractor will apply to Section C for non-subcontractors or non-panel alternative providers.

D. GENERAL POLICIES AND PROCEDURE

1. DBH will produce and distribute a handbook to all enrollees who seek services. The handbook will provide information pertaining to the amount, duration, and scope of benefits available in sufficient detail to ensure that enrollees understand the benefits covered by DBH and how to access those services. Enrollee information will include the extent to which, and how, enrollees may obtain benefits from out-of-network providers and how, after hours and emergency coverage are provided, including what constitutes emergency medical condition, emergency services and post stabilization services.

2. DBH provides information on its process and procedures for obtaining emergency services, including use of the emergency telephone system. The

locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. DBH will inform enrollees of their right to use any hospital or other setting for emergency care.

3. DBH will notify DHHS of any intended change that would mean the information contained in the Medicaid Member Handbook would no longer be accurate and up to date.

4. DHHS will determine if the change is a significant change.

5. DBH will give each enrollee written notice of any change that DHHS defines as significant. The written notice will be 30 days before the intended effective date of the change.

6. DBH will make a good faith effort to give written notice of termination of a Subcontractor within 15 days of receipt or issuance of the termination notice, to each enrollee who was seen on a regular basis by the terminated Subcontractor.

7. If DBH is unable to provide necessary services covered under the contract to a particular enrollee, DBH will adequately and timely cover these services by using other out-of-network providers that offer the same level of care for as long as DBH is unable to provide them.

8. DBH will ensure 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 Covered Services to any enrollee.

9. Regular meetings will occur on at least a monthly basis involving UM staff and the DBH Intensive Services Director to review and approve payments and denials of inpatient billing requests.

10. Davis Behavioral Health will provide Medically Necessary Covered Services in a manner that addresses:
    a. Prevention, diagnosis, and treatment of mental health impairments.
    b. The ability of the client to achieve age-appropriate growth and development, and
    c. The ability to attain, maintain or regain functional capacity.

11. Davis Behavioral Health will provide, at a minimum, all appropriate Medically Necessary Covered Services in terms of amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. Services at DBH are available for CHEC enrollees.

12. Davis Behavioral Health may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition. Davis Behavioral Health may place appropriate limits on a service based on medical necessity, or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.