

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Utilization Management Program Overview	Utilization Management
Date: 8-94 Last Reviewed by QI Committee: 12-06, 9-07, 5-08, 9-08, 9-09, 10-09, 02-10, 09-10, 09-11 Last Revised by QI Committee: 12-06, 9-07, 5-08, 9-08, 9-09, 10-09, 02-10, 09-10, 09-11	Page: 1 of 7 Policy Number: UM-2

Purpose: To outline the utilization management program for Beacon Comprehensive Behavioral Health Management (Beacon CBHM).

Definitions:

Registration – The process of establishing a patient file and tracking form to assist in the verification of eligibility and benefits, coordination of services, and payment of claims for services that do not require pre-authorization. Registration is recommended but not required for payment of services.

Authorization – The process of approving services for payment. Authorization is required for payment of services and must be obtained prior to service delivery except in emergency situations or following a retroactive review.

Policy:

1.0 Description

- 1.1 Beacon CBHM has developed a Utilization Management Program to ensure appropriate utilization for optimal patient care. An interdisciplinary collaborative effort is used in identifying and actively addressing the critical biological, psychological and social impairments, which have necessitated each patient’s treatment. Each patient’s strengths and resources are evaluated on an ongoing basis as they pertain to continued treatment. Utilization Management decisions are based solely on the appropriateness of care and service and existence of coverage for individual patients and consider the following factors
 - 1.1.1 Diagnosis
 - 1.1.2 Age
 - 1.1.3 Co-morbidities
 - 1.1.4 Complications
 - 1.1.5 Progress of treatment
 - 1.1.6 Psychosocial situation
 - 1.1.7 Home environment, when applicable
- 1.2 Beacon CBHM does not compensate or give financial incentives or bonuses to contracted providers providing services or clinicians conducting reviews, which would impact utilization and/or compromise

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member healthcare by encouraging either under or over-utilization through the approval or denial of services. Practitioners are ensured independence and impartiality in making referral decisions that will not influence hiring, compensation, termination, promotion, or other similar matters. In addition, Beacon CBHM prohibits clinicians from conducting reviews when a conflict of interest is present (e.g., patient is a friend, co-worker, patient, etc.) All employees are advised of these policies at the time of hire and clinical utilization management staff signs a written acknowledgement at the time of hire and again at the time of annual performance review. Contracted providers are made aware of these policies at the time of contracting and through Beacon CBHM newsletters and website.

- 1.3 The Vice-President of Product Management and Compliance, a licensed clinician with five years post-masters experience, has oversight of all administrative aspects of the utilization management program. The Medical Director, a board certified psychiatrist with an unrestricted license to practice in the State of California, has oversight of all clinical aspects of the utilization management program.
- 1.4 The Utilization Management Program is a component of the Beacon CBHM Quality Improvement Program. Bi-monthly reports are submitted to the Quality Improvement Committee for review and the Quality Improvement Committee annually reviews and approves the Utilization Management Program. The Utilization Management Committee and its Program are accountable through the Quality Improvement Committee to the Senior Management Committee, which is the governing body for Beacon CBHM.

2.0 Outpatient Services – Non-urgent Pre-Service Reviews

- 2.1 Initial Requests for Service
 - 2.1.1 An Intake Specialist completes a Pre-Review Screening using a standardized script (Reference Appendix D) and gives routine referrals to an appropriate provider(s) or transfers the call to a licensed clinician to complete a Risk Assessment and/or an Initial Review.
 - 2.1.2 Eligibility is confirmed with the health plan.

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- 2.1.3 Initial registration is completed or authorization is granted.
- 2.1.4 Patient is verbally notified regarding registration or authorization and a notification is mailed or faxed to the provider per UM Timeliness Standards. Reference UM-4 “UM Review Process”.
- 2.1.5 A licensed clinician with five years post-masters experience has oversight for all aspects of referral and triage.
- 2.2 Continued Authorization/Denial of Outpatient Services
 - 2.2.1 Registrations do not require additional review. Claims are processed up to the allowable benefit.
 - 2.2.2 Authorizations are limited regarding time frame and services. Requests for continued service authorization require review. Providers are advised to submit authorization requests one visit prior to the last authorized visit.
 - 2.2.3 Direct provider contact via phone, mail, fax, or email will provide the necessary clinical information for additional authorization.
 - 2.2.4 At the time a request for continued services is received, eligibility will be verified with the health plan.
 - 2.2.5 Requests for continued services are reviewed by administrative staff using an algorithm checklist or by a licensed clinician.
 - 2.2.6 The review, authorization or registration, and notification are to be completed per UM Timeliness Standards. *Reference UM-4 “UM Review Process”.*
 - 2.2.7 Mailing or faxing an authorization or registration letter completes notification.

3.0 Authorization of Inpatient, Day Treatment, or Intensive Outpatient Services – Urgent Pre-Service Reviews

- 3.1 Initial Authorization
 - 3.1.1 Provider will provide clinical information to Beacon CBHM utilization management (UM) Coordinator or On-Call Clinician, both of whom are licensed clinicians.
 - 3.1.2 Beacon CBHM UM Coordinator or On-Call Clinician will complete an Initial Review and determine medical necessity according to established clinical indicators. Verbal notification of authorization is given. If after hours, an eligibility disclaimer will be given indicating that authorization is given based upon medical

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necessity and that eligibility cannot be confirmed until regular business hours.

- 3.1.3 The review, authorization or registration, and notification are to be completed per UM Timeliness Standards. *Reference UM-4 “UM Review Process”.*
- 3.2 Continued Authorization – Urgent Concurrent
 - 3.2.1 Beacon CBHM UM Coordinator will review ongoing clinical information provided by the Provider in order to determine medical necessity. Notification will be per UM Timeliness Standards. *Reference UM-4 “UM Review Process”.*
 - 3.2.2 Authorization for urgent concurrent care cannot be discontinued until the member’s treating provider has been notified of the decision and a care plan has been agreed to by the treating provider. If the treating provider is not in agreement, the denial and appeal process will be followed. *Reference UM-6 “Denial and Appeals Overview.”*

4.0 Denials

- 4.1 A registration is not a service authorization and does not guarantee payment of services. Registrations are valid as long as patient is eligible and benefits are available. No denials are associated with registrations.
- 4.2 Once an authorization has been granted it cannot be rescinded or modified after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the plan’s subsequent rescission, cancellation, or modification of the enrollee’s or subscriber’s contract or the plan’s subsequent determination that it did not make an accurate determination of the enrollee’s or subscriber’s eligibility. Beacon CBHM does not reverse authorization decisions for services provided under an approved authorization. Beacon CBHM closes authorizations for future services once a determination of ineligibility or exhaustion of benefits has been made. Closed authorizations are mailed or faxed to the provider within one business day following eligibility or benefit determination.
- 4.3 Based upon the health plan delegation agreement, Beacon CBHM makes either a denial determination or a denial recommendation to the health plan designee who will make the final denial determination.

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- 4.4 A clinical denial determination or a denial recommendation to health plan designee will be made following a Peer Review in which a determination has been made that clinical information does not indicate medical necessity according to Beacon CBHM and Health Plan Clinical Criteria. Only the Beacon CBHM Medical Director or designated Physician Advisor may determine or recommend a clinical denial. The denial determination or the denial recommendation will be communicated to the patient and provider per UM Timeliness Standards. *Reference UM-4 “UM Review Process”.*
- 4.5 An administrative denial determination or an administration denial recommendation to health plan designee will be made whenever the patient’s benefit plan has been exhausted, the request is not covered under the benefit, the provider is non-contracted and there is no out-of-network benefit, or the patient has become ineligible with their health plan. Administrative denial determinations or recommendations may be made by any Beacon CBHM licensed clinician. The determination or recommendation to deny will be communicated to the patient and provider or health plan designee per UM Timeliness Standards. *Reference UM-4 “UM Review Process”.*
- 4.6 Written notification of denial determination will be sent to patient and provider by mail or fax per *UM Timeliness Standards. Reference UM-4 “UM Review Process”.* Notification will include instructions for appeal.

5.0 Appeals

- 5.1 Either a provider or a patient, or patient’s representative may appeal a denial decision.
- 5.2 A verbal description of the appeal procedure will be made available via telephone and a written description is included in each denial letter.
- 5.3 Beacon CBHM is not delegated for appeals. All appeal reviews and decisions are conducted by the health plans.
- 5.4 Beacon CBHM staff assist in coordinating appeals with the appropriate health plan reviewer.

6.0 Communication with CBHM/CHIPA

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- 6.1 A Beacon CBHM representative is available 8:30 a.m. to 5:00 p.m., Monday-Friday.
- 6.2 Voice mail is also available 24 hours a day for callers wishing to leave routine messages.
- 6.3 To contact a Beacon CBHM representative during non-business hours voice mail instructions are available for either leaving a routine voice mail or for paging the On-Call Clinician for urgent or emergent situations. All urgent and emergent calls are responded to within ten minutes.

7.0 Confidentiality

- 7.1 Patient-specific information obtained during the utilization management process will be kept confidential as required by law. Reference RR-6, Confidentiality.
- 7.2 Confidential patient-specific information is used solely for the purpose of utilization management, quality management, disease management, discharge planning, case management, authorization, and claims payment.
- 7.3 Only those third parties under contract or affiliated with Beacon CBHM will be authorized to receive patient-specific utilization management information. Reference HP-8, Release of Personal Health Information.
- 7.4 Patient medical records will be maintained in a secure file with access to only authorized personnel.
- 7.5 All outgoing patient medical records will be labeled confidential and sent by federal express or registered mail to ensure receipt by appropriate party.
- 7.6 Provider credentialing records will be utilized for internal purposes only and will be maintained in a secure file with access to only authorized personnel.
- 7.7 Provider-specific utilization data is not released to entities outside of Beacon CBHM. This data is used internally for purposes of quality management.

8.0 Members' and Providers' Satisfaction with UM Program

- 8.1 Member and provider satisfaction is evaluated periodically either by Beacon CBHM or by the payer.
- 8.2 Corrective action plans are developed as needed in response to survey results.

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8.3 Both corrective action plans and outcomes are reported to the QI Committee.

9.0 Complaints

- 9.1 Beacon CBHM will respond to all complaints initiated by enrollees, patients or health care providers within 30 calendar days of receipt.
- 9.2 All formal complaints and responses will be recorded and filed for a minimum of two years.
- 9.3 A quarterly summary of complaints is reviewed in the Quality Improvement committee.

10.0 Notification of Utilization Management Policies and Procedures

- 10.1 Contracted providers receive notification regarding Utilization Management Policies and Procedures, which include the criteria used to authorize, modify, or deny healthcare services to the public at the time of contracting and whenever Policies and Procedures are updated. In addition, copies may be requested, which are then sent by mail, fax, or email within one business day of receipt of request.
- 10.2 Employees review Utilization Management Policies and Procedures during initial training period and whenever Policies and Procedures are updated. In addition, employees have access to all Policies and Procedures through shared file access.
- 10.3 Patients and/or the public may request copies of Utilization Management Policies and Procedures, which include the criteria used to authorize, modify, or deny healthcare services to the public. The requested documents are then sent by mail, fax, or email within one business day of receipt of request.
- 10.4 The Beacon CBHM website, www.comprehensivebehavioral.com, which is accessible to contracted providers, patients, the public, and employees, references Policies and Procedures related to Utilization Management.