Purpose: Establishing medical necessity for proposed mental health or substance abuse services

This policy and procedure also establishes when to determine benefits, verify eligibility, and comply with in-network requirements when appropriate.

Responsibility: The initial clinical reviewer with concurrence of the Clinical Peer Reviewer (CPR) or designee.

Policy and Procedure:

1. Services usually requiring prior authorization include

   - Hospital admission
   - Outpatient Services
   - 23 hour observation
   - Emergency Department
   - Intensive outpatient sessions
   - Partial Hospitalizations
   - Home Healthcare

2. The benefit plan document should be consulted, as requirements for pre-certification may vary.

Outpatient Referrals

1. Outpatient referral requests must come from the primary physician, unless the consumer has a plan that allows self-referral.

2. When the consumer can self-refer, he or she must notify American Behavioral of the specialist visit.

3. If the referral meets the following administrative requirements, an authorization number is assigned:

   - Eligibility verified;
   - Benefit availability verified;
   - Admitting physician and hospital are in network or the consumer has an out-of-network benefit;
   - Coordination of benefits verified;

- Diagnosis or symptomology recognized by DSM IV; and
- Appropriate level of care for stated clinical status verified.

4. The consumer is financially responsible for any copays or deductibles according to the terms of the policy.

5. If a consumer has out-of-network benefits and elects to use those benefits, the consumer is responsible for ensuring that American Behavioral is notified of the outpatient referral.

6. In a case where the consumer chooses to use out-of- network benefits, the non-clinical associate or initial clinical reviewer gives a certification if criteria are met. The out-of-network benefit applies, and the consumer is financially responsible for the difference according to the terms of his or her policy.

Elective Requests
Examples are: Eating Disorders, Substance Abuse Programs, Residential, etc.

1. Requests for elective pre-certification may be telephoned into the initial clinical reviewer during regular working hours. (See *Policy and Procedure # MBH 24: American Behavioral Business Hours.*)

2. The initial clinical reviewer documents in the American Behavioral System the date and time the request is received.

3. Elective admissions that are not pre-certified are possibly non-certified or paid at a significantly lower benefit level. This depends on the client organization's contract with American Behavioral.

4. Hospitals, physicians and other providers are not required to provide numerically coded diagnoses or procedures.

5. Admissions that meet the criteria are certified, as quickly as the patient's health requires and within applicable regulatory timeframes (See *Policy and Procedure # MBH 911: Turnaround Timeframes.*)

6. The initial clinical reviewer assigns a length of stay based on clinical judgment and approved criteria

7. The following information is given to all interested parties, which may include the provider, the hospital and the patient:

   - The authorization number;
   - The number of extended days or units of service,
   - The next anticipated review point;
   - The new total number of days or services approved; and
   - The date of admission or onset of services.

8. The initial clinical reviewer provides written notification of any certification upon request of the attending physician, any other ordering provider and/or the facility rendering services.

9. The initial clinical reviewer follows Policy *and Procedure # MBH 7: Lack of Information* for any case that requires additional information for reaching a decision follows

   The initial clinical reviewer or CPR may request an extension for an elective, non-urgent decision if the consumer's health is not in jeopardy. (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)

11. With every admission, the initial clinical reviewer completes the admission screen in the American Behavioral System.

12. Issuance of a certification number does not guarantee benefits.

13. An authorization number is issued based on information received at the time of precertification. Upon discovery of any new or omitted information, the authorization may be withdrawn. The pre-certification process begins again using the new information.

14. The requesting provider does not receive a certification number if the proposed admission does not meet admission criteria. However, the initial clinical reviewer enters the authorization request into the American Behavioral System for tracking purposes.

15. The initial clinical reviewer immediately refers all cases not meeting admission criteria to the CPR or designee.

16. The CPR or designee reviews the initial clinical reviewer's documentation. He or she either:

    - Immediately approves the admission or
    - Talks directly to the ordering physician to obtain further justifying information and clarification; or
    - Renders a non-certification.

17. Upon request, information about the admission criteria is made available to the attending physician and to the consumer as copyright law allows.

18. The initial clinical reviewer or designee notifies the admitting physician by telephone of the certification or non-certification decision as quickly as the consumer's health requires and within applicable regulatory timeframes (See *Policy and Procedure # MBH 911: Turnaround Timeframes.*)

19. When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, the initial clinical reviewer tells the provider about the opportunity to discuss the non-certification decision with the CPR making the initial determination or designee. (See *Policy and Procedure # MBH 11: Peer-to-Peer Conversation (Was Request For Reconsideration*.)

20. The initial clinical reviewer sends the provider and patient written notification (via fax or postal service) of any non-certification decisions within applicable regulatory timeframes (See *Policy and Procedure # MBH 911: Turnaround Timeframes.*)

21. Only the CPR or designee may non-certify an elective admission based on clinical judgment and approved criteria.

22. For tracking purposes, the initial clinical reviewer documents in the American Behavioral System the date and time the decision is made.

23. For tracking purposes, the initial clinical reviewer documents the turnaround time for each prospective review in the American Behavioral System.

24. For easy data extraction and concise reporting, the initial clinical reviewer uses formatted charting for documenting all case reviews in the American Behavioral System

25. When a patient is admitted to and in-network facility for an elective admission, it is the admitting physician's responsibility to pre-certify the admission.

26. The admitting physician and the facility may agree to allow the facility's review department to give the initial clinical reviewer pertinent information to pre-certify the admission.

27. If the physician or facility repeatedly fails to comply with pre-certification requirements, physician or facility sanctions may result.

28. The initial clinical reviewer conducts initial review after the patient is admitted and confirmation is made of the original information given at the time of pre-certification.

Urgent or Emergent Admission Requests

1. The Clinical Services Department (Clinical Services) uses the following definitions related to urgent/emergent services:

   - Emergency condition is a mental disorder or substance use disorder manifesting itself by acute symptoms of sufficient severity, including pain, such that the absence of immediate behavioral health services could reasonably be expected to result in any of the following:

     a. Immediate harm to self or others
     b. Serious and permanent dysfunction to the consumer
     c. Serious impairment of the consumer's functioning
     d. Placing the consumer's health in serious jeopardy

   - Urgent and emergent services are covered without prior authorization in cases where a prudent layperson, acting

reasonably, would have believed that an urgent or emergency medical condition existed.

- Examples of an emergency include:

  a. A consumer who is in imminent danger of suicide, as evidenced by a clearly defined plan and history of suicide attempts requiring medical or psychiatric treatment
  b. A consumer who threatens to seriously injure a named or clearly designated person within a specified period of time,

- Emergency treatment is the immediate and unscheduled behavioral health screening, examination and evaluation of a consumer by a physician to determine if an Emergency Condition exists and, if it does, the care and treatment necessary to relieve or eliminate the emergency condition.

- Emergency admission is medically necessary behavioral health services which are immediately required because the consumer is experiencing a severe level of symptoms according to a DSM-IV diagnosis and is impaired in his or her functioning to the extent that he or she presents an immediate danger of harm to self or others.

2. A consumer requiring emergency services usually comes to the attention of Clinical Services in one of the following ways:

   - The consumer contacts Clinical Services, and in the course of the assessment the patient evidences need for emergency intensive services
   - A facility contacts Clinical Services and requests emergency services
   - An American Behavioral provider requests a step up to emergency services from a lower level of care (e.g. routine outpatient services)
   - The consumer's physician or provider has identified symptoms or behaviors requiring an emergency assessment

3. Urgent and emergent services are covered without prior authorization in cases where a prudent layperson acting reasonably would have believed that an urgent or emergency medical condition existed.

4. The initial clinical reviewer or CPR may decide whether a case is urgent or emergent according to accepted definitions of the terms. An exception is when the physician with knowledge of the consumer's medical condition states that the non-urgent time frame would jeopardize the consumer's health.

5. Pre-certification for urgent or emergency care follows the same procedure as that for elective admissions. The initial clinical reviewer applies the same admission review criteria and all Clinical Services policies and procedures apply.

6. The initial clinical reviewer and CPR follow all applicable regulatory timeframes for emergent or urgent admission requests (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)

Emergency Department Admissions

1. The initial clinical reviewer receives requests for certification via phone call following the emergency department admission

2. The initial clinical reviewer documents the information into the American Behavioral System, reviewing the nature of the situation.

3. If the admission is deemed emergent, the initial clinical reviewer follows the procedures for elective admissions.

4. If the admission is deemed non-emergent, it is noted in the American Behavioral system that the participating hospital and physician did not follow proper pre-certification procedures.

5. For emergency department visits that are not pre-certified, the initial clinical reviewer performs a retrospective review to determine medical necessity and benefit eligibility.

6. The initial clinical reviewer bases retrospective review of emergency department visits on the particular diagnosis on the emergency department claim. This could prompt a request for medical records from the facility. (See *Policy and Procedure # MBH 26: Requesting Medical Records.)*

Non-Emergent Admissions At Participating Facilities

1. Requests for authorization are received by Clinical Services via phone, letter or fax.

2. The initial clinical reviewer makes sure that the following administrative requirements are met:

   - Eligibility verified;
   - Benefit availability verified;
   - Admitting physician and hospital are in network or the consumer has an out-of-network benefit;
   - Coordination of benefits verified; and
   - Diagnosis or symptomology recognized by DSM IV.

3. The initial clinical reviewer compares the stated clinical information with Clinical Services criteria, looking at intensity of services required.

4. If criteria are met, the following information is given to all interested parties, which may include the provider, the hospital and the patient The authorization number;

   - The anticipated review point;
   - The total number of days or services approved; and
   - The date of admission or onset of services.

5. The initial clinical reviewer begins concurrent review based upon the intensity of service and the severity of illness after initial certification either on-site or telephonically.

6. If criteria are not met, the initial clinical reviewer refers the case to the CPR or designee.

7. If additional information is required, the CPR may make telephone contact with the admitting doctor to obtain information.

8. The CPR may consult an expert in the same specialty when needed.

9. The CPR documents his decision on the *Clinical Peer Reviewer Determination Form*, returning it to the initial clinical reviewer.

10. If the CPR issues a non-certification, the initial clinical reviewer notifies the admitting physician directly by telephone.

11. When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, the initial clinical reviewer tells the provider about the opportunity to discuss the non-certification decision with the CPR making the initial determination or designee. (See *Policy and Procedure # MBH 11: Peer-to-Peer Conversation (Was Request For Reconsideration*.)

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12. The initial clinical reviewer notifies both the admitting physician and the consumer of their expedited and/or standard appeal rights.

13. Follow-up correspondence is generated by the initial clinical reviewer within applicable regulatory timeframes (See *Policy and Procedure # MBH 911: Turnaround Timeframes.)* The correspondence is mailed or faxed to the facility, physician and consumer.

14. If administrative requirements are not met, the initial clinical reviewer enters data into the American Behavioral System, with the status of the authorization set to "administrative non-certification."

15. If criteria are not met because the admitting provider and/or hospital are out of network, the initial clinical reviewer investigates the reason for the patient using a non-participating physician or hospital.

16. The initial clinical reviewer reviews the case with the CPR if necessary to determine if an exception is appropriate.

17. The initial clinical reviewer certifies the admission if the situation warrants the use of a non-participating provider or hospital, or if the exception was approved prior to the admission due to special circumstances.

18. The initial clinical reviewer does not certify an admission to a non-participating provider and/or hospital if the exceptions listed in paragraph 17 do not exist.

19. If a consumer has out-of-network benefits and elects to use those benefits, the consumer is responsible for ensuring that American Behavioral is notified of the admission.

20. In a case where the consumer chooses to use out-of-network benefits, the initial clinical reviewer gives a certification if criteria are met. The out-of-network benefit applies, and the consumer is financially responsible for the difference according to the terms of his or her policy.