Service Authorization Requests
May 2017

Purpose

To outline the process Providers/Practitioner will need to take in order to receive reimbursement for services rendered to GOBHI enrolled Members.

Definitions

- Concurrent Request: A request for coverage of care or services made while a member is in the process of receiving the requested care or services, even if GOBHI did not previously approve the earlier care.

- "Licensed Independent Practitioner" means a practitioner who is certified, registered, and/or licensed by a recognized State Board to operate independent of supervision in the delivery of services to enrolled Member's.

- "Organizational Provider" means an organization or facility who is contracted to provide services to GOBHI members.

- "Service Authorization Request" means a Member's initial or continuing request for the provision of a service, including Member requests made by their provider or the Member's authorized representative.

- "Specialty Outpatient" are Applied Behavioral Analysis (ABA), Electroconvulsive Therapy (ECT), Substance Use Disorder – Medically Assisted Therapy (MAT), Bariatric Evaluations, Gender Dysphoria Evaluations, specialty Eating Disorder Treatment, specialty Pain Management Related to the Back.

- Urgent Pre-Service Request: A request for care or services where application of the time frame for making routine or non-life threatening care determinations:
    - Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
    - In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Policy

Approvals will be made based on medical appropriateness of the request, practice recommendations, and Members enrollment with GOBHI.

Authorization Procedure

- Practitioners, Organizational Providers, Members, and authorized representatives of the Member can request authorization of services. Members and authorized representatives are not required to have permission from a PCP or other outside entity prior to requesting services

- Members have direct and timely access to GOBHI's utilization management team and are informed regarding how to receive assistance regarding utilization management.
    - Customer service and utilization management staff are available 8:00 AM to 5:00 PM Pacific Standard Time each business day for calls regarding UM issues.
    - Calls are answered by the customer service team and are transferred to the UM team if the call addresses UM issues other than:
        - Benefit limits, deductibles, and co-pays.
        - Services that have been authorized or not authorized.
    - All staff identify themselves by name, title and organization when initiating or returning calls.
    - Staff can receive inbound communication regarding UM issues after normal business hours by facsimile and voice mail.
    - Communications received after normal business hours are returned on the next business day.
    - GOBHI provides TDD/TTY services.
    - GOBHI provides language assistance through a language line contract for members to discuss UM issues.
    - GOBHI posts information about its availability for callers with questions about UM, including hours of operation, the toll-free number, how to access TDD/TTY services, and language assistance on its website and notifies:
        - All participating practitioners annually in writing (such as by including appropriate information in a provider newsletter) that the information is on the website.
    - All members annually in writing (such as by including appropriate information in a member newsletter) that the information is on the website.

- GOBHI prohibits the use of incentives that encourage inappropriate utilization management decision-making.

- GOBHI affirms that:
    - Utilization management decision-making is based only on appropriateness of care and service and the existence of coverage.
    - GOBHI does not specifically reward practitioners or other individuals involved in utilization management for issuing denials of coverage.

- GOBHI requires the following minimum data for utilization management decision making:
    - Assessment and/or ASAM:
        - Mental Health – Developed or updated within the previous six months.
        - Substance Use Disorders – Developed or updated within the previous thirty days.
    - Service plan developed or updated within the previous thirty days.
    - Progress notes for the previous thirty (30) days, or the maximum available if the individual has been receiving services for less than thirty days.
    - Medication authorization records containing a current record of prescribed medications.
    - Communication with licensed healthcare practitioners:
        - Notes from communications with licensed healthcare practitioners relevant to current request.
            - GOBHI utilization management physician and/or utilization management coordinators direct conversations with licensed healthcare practitioners engaged in individual's care.
            - All other data deemed relevant to decision making by the assigned GOBHI physician.

- Not all services require authorization.
    - GOBHI develops and maintains current list(s) of services that have authorization requirements, as listed in the attached Appendix 1.
    - The following do not require pre-service authorization.
        - Emergency services.
        - Office-based ambulatory care
    - In addition to other mechanisms, this information is communicated to Members and practitioners on GOBHI's website.
    - For general reference purposes, the authorization requirements that were current as of the date of approval of this procedure are included as Appendix 1 to this procedure. The most current information can be found on GOBHI's website.

- Emergent & Urgent Sub-Acute and Acute Care Placements:
    - In the event that a Member is placed into either a sub-acute or acute care facility, the provider will be required to notify GOBHI within 24 hours Monday

through Friday and prior to noon on the first business day following the weekend following a placement during the weekend.

- Failure to make notification within the required time frames may delay or prevent payment of otherwise appropriate claims, and can result in a Corrective Action Plan.

- Concurrent Request:
  - Time frame:
    - GOBHI makes a decision and provides written or electronic notification of the decision to the practitioner within 24 hours of receipt of the request.
  - Extensions:
    - GOBHI may extend the time frame by an additional 24 hours if:
      - The request to extend care was not made prior to 24 hours before the expiration of the prescribed period of time or number of treatments.
      - The request to approve additional days for care is related to care not approved by GOBHI previously and GOBHI documents that it made at least one attempt to obtain the necessary information within 24 hours of the request, but was unable to.

- Urgent Preservice Request:
  - Time Frame:
    - GOBHI makes a decision and provides written or electronic notification of the decision to the practitioner within 48 hours of receipt of the request.
  - Extensions:
    - In rare instances, GOBHI may extend the time frame due to a lack of information once, for 48 hours, under the following conditions:
      - Within 24 hours of receipt of the request, GOBHI asks the member or the member's representative for the information necessary to make the decision.
      - GOBHI gives the member at least 48 hours to provide the information.
      - The extension period, within which GOBHI must make a decision, begins:
        - On the date when GOBHI receives the member's response (even if not all of the information is provided), or;
        - At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.

        - In accordance with OAR 410-141-3420 (7) (b), GOBHI will ensure that at least 95% of authorization decisions in this category are made within the initial time frame.
    - Note that this category includes:
        - Authorizations for alcohol and drug services.
        - Expedited prior authorizations, as referenced in OAR 410-141-3420 (7) (d).

- Nonurgent Preservice Requests:
    - Time Frame:
        - For all other prior authorization requests, GOBHI makes a decision and provides written or electronic notification of the decision to the practitioner within 14 calendar days of receipt of the request.
    - Extensions:
        - If the request lacks clinical information, GOBHI may extend the time frame up to 14 calendar days, under the following conditions:
            - GOBHI asks the member or the member's representative for the specific information necessary to make the decision within the decision time frame.
            - The extension period, within which GOBHI must make a decision, begins:
                - On the date when GOBHI receives the member's response (even if not all of the information is provided), or;
                - At the end of the time period given to the member to supply the information, if no response is received from the member or the member's authorized representative.

- Postservice Request:
    - Time Frame:
        - GOBHI makes a decision and provides written or electronic notification of the decision to the practitioner within 30 calendar days of receipt of the request.
    - Extensions:
        - If the request lacks clinical information, GOBHI may extend the time frame up to 15 calendar days, under the following conditions:
            - GOBHI asks the member or the member's representative for the specific information necessary to make the decision within the decision time frame.
            - The extension period, within which GOBHI must make a decision, begins:

- On the date when GOBHI receives the member's response (even if not all of the information is provided), or;
- At the end of the time period given to the member to supply the information, if no response is received from the member or the member's authorized representative.

- Members or their authorized representative may voluntarily agree to extend the decision-making time frame for authorization requests. In instances where the member or authorized representative did not request the extension, GOBHI will justify to the Oregon Health Authority, upon request, how the extension is in the member's best interest.

- A healthcare professional with the appropriate clinical expertise will review all authorization requests.
  - GOBHI will utilize current practice guidelines, evidenced based practices and accompanying service intensity, frequency, and duration recommendations, and consultations with requesting practitioner/provider when making authorization decisions.
  - Decisions to deny, reduce, or suspend services will be reviewed by the Chief Medical Officer or appropriately licensed designee prior to the delivery of a Notice of Action (NOA).

- GOBHI differentiates decisions based on medical necessity and clinical appropriateness from those based on benefit limitations and administrative criteria.
  - Medical necessity decisions are based on applying Medical Necessity Criteria to requests for coverage of care or services that are covered benefits as well as care or services that may be covered or not covered depending on the circumstances. Steps will include review of a request by a licensed health care practitioner operating within the scope of the practitioner's license for determination that:
    - The services requested are safe, effective, and consistent with nationally accepted standards;
    - The services are not experimental or investigational;
    - The services are individualized, specific, and consistent with the individual's signs, symptoms, history, and diagnosis;
    - There is clear and convincing evidence within the assessment that a behavioral health condition exists;
    - This behavioral health condition has a detrimental impact on the health and functioning of the individual;

- The services identified for treatment have a historical pattern of ameliorating the symptoms or will help restore and maintain the individual's health and functioning.

- Clinical appropriateness decisions are based on applying criteria other than Medical Necessity Criteria to requests for coverage of care or services that are covered benefits as well as care or services that may be covered or not covered depending on the circumstances. For example, a request for coverage of out of network care when the benefit limits out of network coverage to care or service that cannot be provided in-network is a clinical appropriateness determination.

Medical Necessity Criteria:

- GOBHI maintains and updates a comprehensive set of Medical Necessity Criteria. As defined elsewhere in this document, this set of criteria may consist of:
  - Criteria adopted from organizations that develop medical necessity criteria.
  - Criteria adopted, with modifications, from organizations that develop medical necessity criteria.
  - Criteria developed by GOBHI.

- GOBHI's uses MCG Health Behavorial Health Care guidelines to determine Medical Necessity.
  - https://www.mcg.com/wp-content/uploads/2016/11/MCG-Behavioral-Health-Care-Guidelines-for-Providers.pdf
  - https://www.mcg.com/wp-content/uploads/2016/11/MCG-Behavioral-Health-Care-Guidelines-for-Payers.pdf

- GOBHI has established a hierarchy among its approved Medical Necessity Criteria.
  - When selecting a set of MCG criteria, GOBHI's staff utilize diagnosis- based criteria if available.
  - If that set of Medical Necessity Criteria does not contain criteria appropriate to the decision to be made, staff can then utilize the level of care guidelines.
  - The final step, should condition or procedure specific criteria not be available among the approved Medical Necessity Criteria, is to base the decision on GOBHI's General Medical Necessity Criteria.

- For documentation requirements related to specialized services see the following policies:
  - Applied Behavioral Analysis (ABA) Initial Prior Authorization (300.30.2)
  - Applied Behavioral Analysis (ABA) Reauthorization (300.30.03)

- The Medical Necessity Criteria used by GOBHI are designed to be clinically flexible, covering a wide range of clinical circumstances and presentations. Such criteria, however, cannot cover every potential set of circumstances.
    - In addition to the clinical flexibility inherent in the Medical Necessity Criteria, GOBHI accommodates the individual clinical needs of the Member and the capabilities of the local delivery system during the review by a Physician Reviewer.
    - When the Utilization Management Coordinator cannot authorize the requested care based on the information available, the case is referred to a Physician Reviewer.
    - The Physician Reviewer considers the individual clinical needs of the Member in rendering a Medical Necessity decision.
    - The needs considered include as applicable, but are not limited to:
        - Age.
        - Comorbidities.
        - Complications.
        - Progress of treatment.
        - Psychosocial situation.
        - Home environment.
    - When considering the individual circumstances, the Physician Reviewer is expected to make a clinically appropriate decision, within the limits of the Member's benefit structure, which may be different from the decision suggested by the medical necessity criteria.
    - The Physician Reviewer also considers the characteristics and capabilities of the local delivery system, including, but not limited to, the available services in the local delivery system and their ability to meet the Member's specific health care needs.
    - If the appropriate level or setting of care is not available within a reasonable geographic distance from the Member's location, GOBHI authorizes the next highest level of care that is available provided that the clinically indicated level of care is a covered benefit.

- General: The following General Medical Necessity Criteria are used when there are no diagnosis- or procedure-specific criteria applicable to the situation. All criteria must be met for the service to be considered medically necessary.
    - The services are prescribed by a licensed health care practitioner practicing within the scope of his/her license in the context of his/her treatment of the individual.
    - The services are safe, effective, and consistent with nationally accepted standards of medical practice.
    - The services are not experimental or investigational.
    - The services are individualized, specific, and consistent with the individual's signs, symptoms, history, and diagnosis.

- Either:
- The services are reasonably expected to diagnose a disease or condition, provided that all the following are met:
- The screening has a significant probability of detecting the disease or condition.
- The disease or condition has a significant detrimental effect on the health status of the affected individual.
- Effective evidence-based methods of treatment are available for treating the disease or condition at the stage which the screening is designed to detect.
- Treatment in the asymptomatic phase has been demonstrated to yield a therapeutic result OR
- The services are reasonably expected, in a clinically meaningful way, to:
    - Help restore or maintain the individual's health, or
    - Improve or prevent deterioration of the individual's disorder or condition, or
    - Delay progression of a disorder or condition characterized by a progressively deteriorating course when that disorder or condition is the focus of treatment for this episode of care.
- The individual complies with the essential elements of treatment.
- The services are not primarily for the convenience of the individual, Practitioner, caregiver, family, or another party.
- Services are not being sought as a way to potentially avoid legal proceedings, incarceration, or other legal consequences.
- The services are not predominantly domiciliary or custodial.
- No exclusionary criteria of the plan or benefit package are met.

- Written copies of guidelines related to a specific authorization are available upon request by contacting the UM Department at GOBHI at 1-541-298-2101 or 1-800-493-0040.

Denials

- Benefit denials are those for services that are specifically excluded from a Member's benefit plan and thus not covered by GOBHI under any circumstances. A benefit denial also includes denials of requests for extension of treatments beyond specific numeric limitations and restrictions (such as number of units of service or age) imposed in the Member's benefit plan. The process for determining whether a benefit denial exists consists of a review of the request by a licensed health care practitioner operating within the scope of the practitioner's license for determination of whether:
    - There is clear and convincing evidence within the assessment that a behavioral health condition exists;
    - The behavioral health condition has been determined by the Health Evidence Review Commission (HERC) of the State of Oregon to be a covered condition;

- The services requested, if condition is covered under HERC guidelines, have been approved by HERC in treating the covered condition;
- Service extension requests will be reviewed based on HERC guidelines governing those services.

- Administrative denials are those where an official requirement has not been met. Administrative denials are commonly issued for services that required prior-authorization when such authorization was not requested or obtained prior to delivery of the service.

- Notices of Action:
  Upon review by GOBHIs' Chief Medical Officer, when a denial, reduction, or suspension is authorized, GOBHI's NOA policies and procedures will be followed (200.71.01).

- Appeals:
  - GOBHI makes every reasonable effort to avoid disagreement with Members, Practitioners and Providers related to UM decisions. If unsatisfied with a UM decision, the Member and Member Representative (including Treating or Rendering Practitioner acting on behalf of the Member) have the right to initiate an Appeal of the decision.

  - When an Appeal involves an approved ongoing course of treatment to be provided over a period of time or number of treatments that GOBHI has decided to reduce or terminate, GOBHI continues coverage for the approved ongoing course of treatment without liability to the Member until the Member is notified of the Appeal decision or until the approved ongoing course of treatment has been provided, whichever comes first.

  - Each Appeal is conducted by one or more Appeal Reviewers:
    - Who were not involved in the UM Adverse Determination that is the subject of the Appeal.
    - Who are not subordinates of any person involved in the UM Adverse Determination that is the subject of the Appeal.
    - One of whom, for Appeals involving Medical Necessity or Clinical Appropriateness, including whether a particular treatment, drug or other item is experimental or investigational, is a Same or Similar Specialist.

  - GOBHI maintains a list of specialty and sub-specialty doctoral level behavioral health Practitioners who serve as Physician Reviewers as well as a contract with an organization for the provision of Same-or-Similar-Specialist Physician Reviewers as needed. This list and contract cover all major recognized behavioral health specialties

- At any time during the Appeal process, a Member may choose to designate a Member Representative to participate in the Appeal process on his/her behalf. Members are informed of their right to have a Member Representative act on their behalf in the initial denial notification letter, and at all levels of appeal as follows:

  "You have the right to be represented by anyone you choose and have that representative act on your behalf at all levels of appeal. You can name a relative, friend, advocate, doctor, attorney, or someone else to act for you. For more information on filing an appeal or to learn how to name your authorized representative, call, fax, or write to Greater Oregon Behavioral Health, Inc. at…."

- In addition to the Appeals process described in this document, a Member or other involved party, as described above, may request an administrative hearing external to GOBHI. GOBHI cooperates, as required, to permit completion of these Appeals.

Appendix 1

	Type	Authorization Required
Authorization Required		
PES for St. Charles	Acute/Emergent	Yes
PES for Unity	Acute/Emergent	Yes
Respite (Adult and Children)	Crisis/Respite	Yes
Including: Home based respite for children	Crisis/Respite	Yes
Acute Hospitalization	Inpatient	Yes
Acute Non-Hospital	Inpatient	Yes
Detox	Inpatient	Yes
Harney District Hospital Lake District Hospital	Inpatient Emergency Transport Hold	Yes
Residential Treatment (PRTS)	Residential	Yes
Residential Treatment – Dual Diagnosis/Co-occuring	Residential	Yes
SUD Residential	Residential	Yes
ABA	Outpatient - Specialty	Yes
ECT	Outpatient - Specialty	Yes
SUD-MAT	Outpatient - Specialty	Yes
Bariatric Evaluation	Outpatient - Specialty	Yes
Gender Dysphoria Evaluation	Outpatient - Specialty	
Eating Disorders	Outpatient - Specialty	Yes
Pain Management related to the Back	Outpatient - Specialty	Yes
Single case agreement	Single case agreement	Yes
Services not on this list		Yes
No Authorization Required		
SUD outpatient Adults and Children	Outpatient	No
BRS Outpatient Psychiatric Day Treatment	Outpatient Outpatient	No No
Emergency Services	Outpatient	No
SUD IOP Children	Outpatient	No
SUD IOP Adult	Outpatient	No
Office visits	Outpatient	No
Tonya's House-wraparound code	Residential, BRS Residential Specialty Care	No
Therapeutic Foster Care: wraparound care	Residential	No
State Hospital		
State Hospital: Adult & Child	State pays for service	N/A