JEFFERSON
BEHAVIORAL
HEALTH

Managed Mental Health Care Organization for Coos, Curry, Douglas, Jackson, Josephine, and Klamath Counties
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ADULT AND CHILD ACUTE & SUB-ACUTE CARE UTILIZATION MANAGEMENT PLAN

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Section

Table of Contents

Introduction and Philosophy — ***1***
- Rationale and Organization of Utilization Process — 1
- Objective — 2

Definitions — ***1***
- Access — 1
- Acute Care — 1
- Appropriate and Necessary Services — 2
- Case Management — 2
- Care Coordination — 3
- Commitment — 3
- Comprehensiveness — 3
- Confidentiality — 3
- Custody — 3
- Diversion Agreement — 3
- Diversion Plan — 4
- DSM IV TR — 4
- Emergency Care — 4
- Hold — 4
- Long Term Psychiatric Care — 4
- Medical Necessity — 4
- Member — 4
- Outpatient Commitment — 5
- Resident — 5
- Transport Hold — 5
- Utilization Review — 5
- Voluntary — 5

Treatment Standards — ***6***

Admission Criteria — ***10***

Inpatient Hospital Admission Criteria — **10**

Sub-Acute Admission Criteria — **10**

Procedure for determination of eligibility for MHS 24 (Indigent) authorization. — ***12***
- Policy — 12
- Procedures — 12

Preauthorization — ***15***

Prospective Review — ***16***
- First Level Prospective Review for Acute and Sub-Acute Care — 16
- Second Level Prospective Review — 17

Inpatient and Continued Stay Review Criteria — ***18***

ACUTE CARE — **18**

Review Criteria 18
Continued Stay Criteria 18

SUB-ACUTE CARE **20**
Sub-Acute Review Criteria 20
Sub-Acute Care Continued Stay Criteria 21
Discharge Planning 22
Discharge Criteria 22

Retrospective Reviews ***23***

Denials and Appeals ***24***

APPENDIX ***26***

Jefferson Behavioral Health Eligibility for Indigent Care Form **26**

Section I Introduction and Philosophy

Jefferson Behavioral Health (JBH) is an intergovernmental agency organized under ORS Chapter 190 for the purpose of contracting with the State of Oregon to provide managed mental health care to Oregon Health Plan enrollees. JBH also provides regional acute care management services and pays for indigent acute care services that are identified as County responsibility under ORS 426.241.

Rationale and Organization of Utilization Process

JBH is by contract required to have written utilization management policies and procedures and criteria for the consistent application of review criteria; for service authorization decisions; service provision verification; consultation with provider requesting services and description of how qualified staff will make those determinations. These policies and procedures must be consistent with the Utilization control requirements of 42 CFR Part 456. Utilization control requirements of 42 CFR Part 456 require written criteria to assess the need for admission and more extensive written criteria for cases that are associated with high costs, associated with frequent furnishing of excessive services and questionable patterns of care.

The JBH utilization management policy and procedure is based on a systems perspective that requires collaboration between the County providers, contracted providers, physical medicine providers, and social service providers. These providers share responsibility for the health and wellness of persons receiving public benefits. It is the policy of JBH to use its influence to mandate collaboration to ensure that resources are being used as efficiently as possible and to ensure that persons eligible for public benefits receive the most effective healthcare available. JBH contracts with County Mental Health Programs in each County in the JBH region to provide care coordination and case management as part of every JBH members' outpatient benefit package. It is essential that care coordination and/or case management be involved in every aspect of the members care in the acute care system. The policy and procedures rely on the involvement of the County Community Mental Health Programs for the authorization and coordination of the provision of services in the acute care system as a way to ensure that services are individualized to each members needs and situation and delivered at the most appropriate level of need available in the broader regional mental health system.

The Utilization Process is described in the following sections. The first provides the criteria used to make a determination about the appropriateness, necessity, comprehensiveness, and timeliness of the treatment provided for the acute care and sub-acute levels of care. The second describes the procedures for clinical reviews and making

authorization decisions. It also describes the procedures for verification and notification of authorizations, and the consultation with providers requesting authorizations. The third section describes of how denials, adverse decisions, and how appeals are handled at the JBH level.

Objective

JBH adopts the following utilization guidelines to place reasonable and allowable limits on covered services and limits on providers of services while ensuring that medically necessary services are provided to members. These guidelines are intended to prevent arbitrary denials or reductions in services and provide clearly stated criteria for use in utilization management decisions and the appeals of those decisions when utilization management decisions are not consistent with these policies and procedures, JBH contracts, or administrative rules.

Section II Definitions

Access

Access is the ease with which a member can enter a provider's network at the appropriate level of care. Accuracy of referral, location of services in relation to members' homes, timeliness of response to service requests, availability of services at every level of care, and the ability to serve high acuity and other difficult problems are aspects of access that are measured. Standards for "Emergent", "Urgent" and "Routine" levels of acuity are monitored and reviewed by the JBH Quality Management Committee.

Acute Care

Acute care means care provided at an inpatient psychiatric facility or sub-acute facility contracted with JBH to provide acute care. Acute Care is facility based treatment provided at one of the following:

1) A Hospital certified or licensed by the State Department of Human Services under OAR 309-032-0850 through 309-32-0890, Standards for Regional Acute Care Psychiatric Services for Adults.
2) A Hospital with a hold room certified by the State Department of Human Services under OAR 309-033-0540 through 309-033-0560, Administrative Requirements for Hospitals and Non-hospital Facilities Approved to Provide Services to Persons in Custody.
3) A Hospital or Non-Hospital facility certified by the State Department of Human Services under OAR 309-033-0530, Approval of Hospitals and Non-hospital Facilities to Provide Services to Committed Persons and Persons In Custody or on Diversion.
4) A Hospital approved by the State Department of Human Services for transport holds under OAR 309-033-0550 through 309-033-0650, Standards for the Approval of Hospitals Detaining Persons in Custody Pending Transport to an Approved Holding Hospital or Non-hospital Facility, OAR 309-033-0600.
5) A Secure or Non-Secure Residential Care Facility licensed by the State Department of Human Services under OAR 309-035-0100 through 309-035-0190.
6) A Residential Treatment Home licensed by the State Department of Human Services under OAR 309-035-0250 through 309-035-0600.
7) A Child/Adolescent Residential Psychiatric Treatment Service licensed by the State Department of Human Services under OAR 309-034-0150 through 309-034-0320.

Appropriate and Necessary Services

Appropriate and necessary services are typically understood to be reflected in several criteria; that the services are necessary for treatment of the focus problem, that the services are generally professionally accepted and not considered experimental, and that the problem is likely to be responsive to those particular services. These services refer to medical, hospital or therapy services and supplies for treatment of an active mental disorder which has been established in accordance with generally accepted professional standards and approved for use by JBH's Quality Management Committee.

They are expected to be:

- rendered for the treatment and diagnosis of a mental disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders appropriate for the severity of symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards;

- not furnished primarily for the convenience of the member, the attending physician, or other provider of service (including the provider making referral to inpatient care); and

- furnished at the least restrictive level which may be provided safely and effectively to the member.

In addition, for the services to be eligible for reimbursement there must be a reasonable expectation that the condition of the member will improve or show improvement. Such an expectation would be based both on empirical evidence about efficacy of the procedure and the probability that the member's particular condition will be responsive to the procedure.

Case Management

Case management in the context of utilization management involves close tracking and coordination of care for members who require treatment. The case management function of utilization management performed by ABHA involves intensive clinical review. The utilization management clinician works with each member and his or her provider to ensure that the most effective treatment plan is implemented throughout the member's participation in the Oregon Health Plan. In addition, the JBH's Utilization Manager provides assistance in obtaining needed acute care services in a timely manner. This role sometimes requires intensive assistance to high service use members who have problems obtaining appropriate services.

Care Coordination

As defined in the OAR's,"Care coordination" means a process oriented activity that provides ongoing communication and collaboration with children and families with multiple needs. Care coordination includes: facilitating communication between the family, natural supports, community resources, and involved child-serving providers and agencies; organizing, facilitating and participating in team meetings at which strengths and needs are identified and safety planning occurs; and providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for older youth to the adult service system.

Commitment

Commitment means a mentally ill person admitted or detained under ORS 426.150, 426.223, 426.273, 426.275 or 426.292.

Comprehensiveness

Comprehensiveness of care includes the concepts of appropriateness and continuity. Appropriateness of care is the degree to which the quality and the intensity of services are delivered in the setting most likely to promote positive clinical outcomes. Continuity of care is the degree to which the care provided is based on a consistent and comprehensive treatment plan across the range of necessary services.

Confidentiality

Utilization Management Programs necessarily deal with sensitive information about patients and providers. The documents that are created and reviewed as a part of the utilization management process - electronic and hardcopy case records as well as all oral communication. These records are confidential and privileged information case records and must be treated accordingly. Medical records or other materials used for utilization management shall be considered strictly confidential and retained in a secure environment. All personnel who have access to records must receive training in and be able to demonstrate an understanding of HIPPA and applicable state laws.

Custody

Custody means a person admitted or detained; or under ORS 426.070, 426.140, 426.228, 426.232 or 426.233.

Diversion Agreement

Diversion Agreement means a mentally ill person on a diversion agreement as provided for in ORS 426.237 (b).

Diversion Plan

Diversion Plan means a person admitted or detained under ORS 426.070, 426.140, 426.228, 426.232 or 426.233 and CMHP submits a plan for a treatment option less restrictive than involuntary in-patient commitment is appropriate in an effort to avoid the necessity for a commitment hearing.

DSM IV TR

The current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Emergency Care

Care that is needed immediately and a delay in care would entail significant risk to the member's health and/or safety. Emergency Care is limited to covered services for a qualifying mental health condition. Emergency Care is only authorized until it is safe for the member to be evaluated by the responsible JBH Community Mental Health Program crisis service and be authorized for the appropriate level of care at a JBH contracted provider.

Hold

Hold means a mentally ill person who is admitted or detained on a hospital or non hospital hold under ORS 426.232.

Long Term Psychiatric Care

Care that is provided at a State Department of Human Services contracted program or a State Hospital after the member has received all usual and customary treatment, including if medically appropriate, establishment of a medication management program and use of a medication override procedure.

Medical Necessity

In considering the appropriateness of any level of care, the four basic elements of Medical Necessity should be present: (1) a diagnosis as defined by standard diagnostic nomenclatures (DSM IV TR or its equivalent in ICD-9-CM) and an individualized treatment plan appropriate for the participant's illness or condition; (2) a reasonable expectation that the participant's illness, condition, or level of functioning will improve through treatment; (3) the treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health professionals; and (4) it is the most appropriate and cost effective level of care that can safely be provided for the participant's immediate condition.

Member

Either:

1) An individual who is enrolled in the Oregon Health Plan and assigned to JBH or who is otherwise covered under an intergovernmental agreement between JBH and the State of Oregon; or

2) Residents of member counties of JBH (Coos, Curry, Douglas, Jackson, Josephine, and Klamath) who have no third party resource or personal resource, and whose income is and legal admission status is determined to be indigent by the County of residence.

Outpatient Commitment

Outpatient Commitment means a mentally ill person who is on outpatient commitment under ORS 426.127.

Resident

Resident means a person who has a current mailing address in the County of residency.

Transport Hold

Transport Hold means a mentally ill person detained for the purposes of transport under ORS 426.150, 426.223, 426.235, 426.273, 426.275 or 426.292.

Utilization Review

Utilization review refers to a determination of the need for a level of care necessary for adequate health and function. Utilization review includes prospective (preauthorization or pre-certification) reviews, concurrent reviews, and retrospective reviews. JBH's utilization review program is designed to match the treatment needs of the individual to the least restrictive and most clinically appropriate setting available.

Voluntary

Voluntary means a mentally ill person who requests voluntary admission under ORS 426.225 (2) and JBH UM staff are consulted prior to the admission and agree that the individual meets criteria for acute care services and services are medically necessary according to the JBH utilization management plan, acute care section

Section III Treatment Standards

Services Provided Must:

1. **Meet National Standards for Mental Health Professional Practice**

   Services provided to JBH members should be safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications

   To be considered medically necessary, treatment must be rendered by appropriately licensed and qualified (e.g., credentials, experience) mental health professionals. Treatment facilities and programs must be appropriately licensed and qualified to provide the level of care determined to be necessary.

2. **Be Provided at the Most Cost Effective Level of Care**

   Services should be provided at the appropriate and most cost effective level of care that can safely be provided for the specific Member's diagnosed condition in accordance with the professional and technical standards adopted by JBH As outlined above, treatment must be "adequate and essential." Treatment at the most appropriate level of care is care that is provided to meet a specific member's clinical needs (structure, process, outcome) at the most reasonable cost.

3. **Be Adequate and Essential for the Evaluation/Treatment of a Mental Disorder**

   Services must be an adequate and essential therapeutic response for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific Member's illness, disease or condition as defined by standard diagnostic nomenclatures (current DSM-IV TR or its equivalent in ICD 9 CM). To be considered medically necessary, services which are provided or proposed must be those services (e.g., psychotherapy, psychopharmacology) which the member clinically requires and which can be reasonably expected to improve the condition

sufficiently so that the member can be served at a lesser level of care.

The adequacy of treatment refers to its clinical appropriateness, completeness, and timeliness. Essential treatment means treatment that is neither more nor less than what is clinically appropriate for the member at a specific point in time.

Treatment may be adequate but not essential if a more restrictive and costly alternative is used than the member clinically requires. On the other hand, treatment may be essential but inadequate, if, for example, a member is hospitalized for a severe mental disorder but is not given appropriate medication in a timely manner.

To be considered medically necessary, treatment must address a mental disorder. Treatment intended solely for self-improvement or for normal life stress, reactions or a court order is not relevant to determining medical necessity. Treatment must address a recognized DSM IV TR diagnosis (qualified by all five axes) -- with the exception of certain diagnoses for which medical/psychiatric intervention is generally not appropriate or for diagnoses not covered under the Oregon Health Plan.

A provider's rationale for treatment should reflect clinical indications and symptoms which have been appropriately interpreted as a diagnosis consistent with one of the categories to be found in the DSM IV TR, or ICD 9 CM. Services must be provided at the appropriate level of care relative to the severity of the member's illness and capacity to respond to professionally provided effective treatment and services by a provider capable of rendering effective treatment for the member's clinical condition.

4. Meet National Standards for Mental Health Professional Practice

Services provided to JBH members should be safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications

To be considered medically necessary, treatment must be rendered by appropriately licensed and qualified (e.g., credentials, experience) mental health professionals. Treatment facilities and programs must be appropriately licensed and qualified to provide the level of care determined to be necessary.

5. Be Provided at the Most Cost Effective Level of Care

Services should be provided at the appropriate and most cost effective level of care that can safely be provided for the specific Member's diagnosed condition in accordance with the professional and technical standards adopted by JBH. As outlined above, treatment must be "adequate and essential." Treatment at the most appropriate level of care is care that is provided to meet a specific member's clinical needs (structure, process, outcome) at the most reasonable cost.

6. Meet the National Standard for Timely Services

JBH supports the following national standards for timely patient evaluation, which apply to any member who is admitted to any acute or sub acute inpatient psychiatric treatment facility.

Within 24 Hours of Admission:

1) History of present illness
2) Previous mental health treatments
3) Relevant family history and developmental history
4) General medical (non-psychiatric) history, including previous treatments
5) Mental status examination
6) Initial diagnostic formulation
7) Individual psychiatric evaluation
8) Initial discharge plan
9) Physician's certification of need at all levels of care and medical clearance if care is provided in a non-medical facility.

Within Two Days of Admission:

1) Assessment of any factors that may complicate treatment, such as substance abuse, physical/sexual abuse, or other co-morbid psychiatric disorders
2) Interdisciplinary treatment team meeting
3) Detailed treatment plan and evidence of implementation
4) Expected discharge plan summary

At Time of Discharge:

1) Written formal discharge plan
2) Discharge treatment team meeting
3) Outpatient Mental Health Care arranged and aftercare plan.

It is expected that a specific aftercare plan will be developed prior to discharge and a designated county staff person will be responsible for assuring that the plan is followed.

Involuntary Treatment and Indigent Care Timeliness Standards Immediately upon admission:

1) Notification of the County where the person was taken into custody of an emergency hold being placed on a member
2) Inform the member of the member's right to representation by or appointment of counsel as described in ORS 426.100
3) Providing the member with warning required in ORS 426.123
4) Immediately examine the member
5) Set forth, in writing, the condition of the member and the need for emergency care or treatment
6) If the physician, nurse or qualified mental health professional reasonably suspects that the member is a foreign national, inform the person of the person's right to communicate with an official from the consulate of the person's country.

7. Importance of Care Coordination

Care coordination is an essential component of JBH's utilization management program. It is a process which focuses on the inpatient episode and involving aftercare providers of physical medicine and outpatient behavioral health providers in the care and planning provided during an inpatient episode as well as engaging them in the aftercare requirements identified during the period of acute care stabilization and treatment. It ensures that when a member is discharged there will be an adequate level of aftercare that has been developed to meet the specific member's needs. Discharge planning should be initiated on the first day of admission and should be a focus of treatment throughout the inpatient episode.

8. Special Considerations

The intensive involvement of the family and/or care providers (e.g., foster parents, group home staff) in child/adolescent treatment is required, unless there are legal restrictions that prohibit contact with specific family members.

9. Service Authorization Decision Criteria

Before certifying medically necessary treatment for admission or continued stay under the Oregon Health Plan or Indigent Care provided under ORS 426, a JBH Utilization Manager must ascertain that treatment level meets the JBH Criteria as well as the additional criteria defined below.

Section IV

Admission Criteria

Inpatient Hospital Admission Criteria

1) The member meets criteria for a non-V-code DSM-IV diagnosis.
   a) OHP members must have a covered diagnosis above the line on the OHP prioritized list of covered diagnoses.
   b) Indigent members must be on a 2-Physician Hospital Hold or on a diversion from commitment approved by the responsible Community Mental Health Program Director or their designee.
2) The decision to admit is based on the member meeting one of the following criteria:
   a) Severe and Acute deterioration in the member's mental status has occurred resulting in symptoms of such severity that there is significant restriction of the member's usual level of social, occupational and/or educational functioning and active symptom management and medically managed supervision and monitoring is necessary over a 24-hour period to ensure adequate safety and care of member.
   b) Severe and Acute risk of harm to self or others due to the psychiatric condition which cannot be mitigated by protective factors in the member's support system and are unmanageable at a lower level of care.
   c) Deterioration in the member's baseline level of functioning has occurred, which has been unresponsive to an appropriate course of treatment at a lesser level of care, and medically managed 24 hour care is necessary.
   d) The member is unable to function in the community and will require support and stabilization for community reintegration that is not available at a lesser level of care.
   e) The member requires skilled observation and frequent assessment of psychiatric status with medical intervention available on a 24 hour basis.
3) A physician has determined that inpatient treatment is medically necessary and the member is placed at the right level of care.
4) A Provisional Treatment plan has been developed that includes clear, time-limited, transition-focused objectives for this treatment phase and a provisional discharge plan.

Sub-Acute Admission Criteria

1) The member meets criteria for a non-V-code DSM-IV TR diagnosis.
   a) OHP members must have a covered diagnosis above the line on the OHP prioritized list of covered diagnoses.

b) Indigent members must be on a Non- Hospital Hold or on a diversion from commitment approved by the responsible Community Mental Health Program Director or their designee.

2) The decision to admit is based on the member meeting one of the following criteria:
   a) Member exhibits Psychotic or Depressive symptoms that are more Severe and Acute than member's baseline mental status and resulting in symptoms of such severity that there is significant restriction of the member's usual level of social, occupational and/or educational functioning and active symptom management and structured supervision and monitoring is necessary over a 24 hour period to ensure adequate safety and care of member.
   b) Member exhibits high risk of harm to self or others due to the psychiatric condition which cannot be mitigated by protective factors in the member's support system and are unmanageable at a lower level of care.
   c) Deterioration in the member's baseline level of functioning has occurred, which has been unresponsive to an appropriate course of treatment at a lesser level of care, and 24 hour supervision and support is necessary.
   d) The member is unable to function in the community and will require support and stabilization for community reintegration that is not available at a lesser level of care.
   e) The member requires skilled observation and frequent assessment of psychiatric status with structure and support available on a 24 hour basis.
3) A physician has determined that sub-acute treatment is medically necessary and the member is placed at the right level of care.
4) A Provisional Treatment plan has been developed that includes clear, time-limited, transition-focused objectives for this treatment phase and a provisional discharge plan.

Section V MHS 24 (Indigent) Authorization Procedure

Policy

It is the Policy of JBH to screen and determine eligibility for the use of MHS 24 (Indigent) funds and ensure that funds are used in compliance with State contract requirements.

Eligibility for Indigent services is determined by the County in which the emergency hold is filed with the Court and will be available by contacting the Community Mental Health Program Monday thru Friday. Eligibility for Indigent care services is contingent upon a number of conditions which are available to providers when requesting an eligibility determination.

All persons who may become eligible as indigent persons must be entered into the PhTech eligibility files before they can be pre-authorized or authorized for acute care (in-patient hospital, crisis resolution or respite care) services.

Only Counties may enter eligibility data for persons who they determine may be eligible for indigent mental health care during a hospital or non-hospital hold, commitment, voluntary diversion, revocation, warrant of detention, voluntary admission or respite care.

Procedures

1) The County of residence or the County in which the individual was taken into custody by a law enforcement officer and evaluated at an emergency room, shall determine a person eligible if they meet all of the following criteria (a) through (d):

   a) An Adult over 18 years of age.

   b) A person meeting one or more of the following criteria;
      i) A person admitted or detained; or under ORS 426.070, 426.140, 426.228, 426.232 or 426.233; or
      ii) A person admitted or detained under ORS 426.070, 426.140, 426.228, 426.232 or 426.233 and CMHP submits a plan for a treatment option less restrictive than involuntary in-patient commitment is appropriate in an effort to avoid the necessity for a commitment hearing; or
      iii) A mentally ill person admitted or detained under ORS 426.150, 426.223, 426.273, 426.275 or 426.292; or

iv) A mentally ill person on a diversion agreement as provided for in ORS 426.237 (b); or
v) A mentally ill person who requests voluntary admission under ORS 426.225 (2) and JBH UM staff agree that they meet the other criteria for acute care services; or
vi) A mentally ill person who is on outpatient commitment under ORS 426.127 on a treatment plan approved by JBH UM staff; or
vii) a mentally ill person as defined by 426.237 (2) as chronically mentally ill and who has been, or there is a high degree of risk that the person will be involved in an acute hospital admission and where the County requests and the JBH UM staff approve a plan of care that has a reasonable expectation of preventing an acute hospital admission then the person will be eligible for a time limited period: and

c) A person who is the responsibility of JBH, determined as follows;
   i) maintains a current mailing address in Coos, Curry, Douglas, Jackson, Josephine or Klamath County; or
   ii) if the person does not maintain a current mailing address within the state, the person was taken into custody in either Coos, Curry, Douglas, Jackson, Josephine or Klamath County; or
   iii) a court committed mentally ill person has been conditionally released in either Coos, Curry, Douglas, Jackson, Josephine or Klamath County: and
d) A person who has no resources or assets to pay the cost of care based on means testing. JBH will consider a number of procedures for means testing including but not limited to the following;
   i) The hospital or facility used their usual and customary procedure to determine that the person is eligible for indigent medical care and agrees to write off any medical charges including medication and labs incurred during the indigent care episode.
   ii) There has been a determination that the person is eligible for food stamps within the past six months in the County where they maintain a current mailing address.
   iii) Earnings are documented and show that the person is below 200% federal poverty level standard.
   iv) Earnings are not documented and there is documentation that the person is disabled and has applied for Social Security Disability or Supplemental Security Income program or has been on SSD or SSI and is not longer on the program for reasons other than employability.

2) The designee of the CMHP responsible for determining eligibility in section 1, shall fax the eligibility form attached to PhTech at (503) 566-9801 the first business day after admission to an acute or sub-acute care facility.

3) The designee of the CMHP responsible for pre-authorizing acute or sub-acute care shall assess the individual and determine if the following criteria are present to make an authorization decision:

   a) Determine that the individual meets the entrance criteria for acute care or sub-acute care as described in the Jefferson Behavioral Health Acute Care utilization management policy and procedures.

   b) Determine that acute or subacute care services are medically necessary using the Jefferson Behavioral Health Acute Care utilization management policy and procedure.

   c) Determine that services are to be provided by specific providers who have an agreement with Jefferson Behavioral Health to provide the medically necessary services.

   d) Determine that all reasonable and appropriate efforts have been made to provide services at the least intrusive and least restrictive setting available at the time of need.

   e) Determine that care coordination standards have been met during the admission process and that providers of outpatient services and relevant adjunct service providers have been notified of the admission.

4) The designee of the CMHP responsible for pre-authorization shall enter the referral for authorization into the PhTech system. All pre-authorizations by the designated CMHP staff shall be effective from the date of admission to the following business day after the pre-authorization was submitted to PhTech. CMHP staff may authorize from the first day that they were aware of the admission.

Section VI Preauthorization Process

JBH or subcontractors will perform utilization review functions for those mental health services requiring prior authorization. Inpatient and sub-acute treatment require prior authorization from JBH or County Mental Health Programs.

JBH contracts with County Mental Health Programs in the JBH region to provide emergency services that are needed immediately, or appear to be needed immediately by a reasonable and prudent layperson, due to sudden onset of a mental health condition. Community Mental Health Programs in the JBH region provide 24 hour response to determine the presence of a covered mental health condition and the degree of urgency for services. The County Mental Health Program subcontractors are responsible for evaluation, stabilization, and referral to an appropriate level of care of all JBH members in the event of a mental health emergency. During the crisis screening the County Mental Health Program shall follow this process:

1) Detailed clinical information is gathered to assess if the situation is emergent, urgent, or routine.
2) If a clinical emergency exists, the local crisis staff will provide crisis stabilization services including transportation for further evaluation, police intervention or other emergency services. Only local County Mental Health Crisis Staff or JBH Utilization Manager can pre-authorize after hours admissions.
3) If a JBH member must be transferred out of area for mental health treatment services, the provider initiating the transfer will:
    a) Notify the member's primary care physician (PCP) of impending transfer (if such transfer is not an emergency).
    b) Notify the member's physical health, fully capitated health plan (FCHP) prior to transfer (if such transfer is not an emergency).
    c) In an emergency situation, both FCHP and PCP shall be notified the next business day.
    d) If the evaluation does not indicate the need for an inpatient admission or admission to a crisis resolution center, the member is referred to the appropriate level of care and provider.
    e) A follow-up call is made to ensure that the referral appointment is kept.

Section VII Prospective Review Process

Prospective review is defined as an evaluation of a provider's request for treatment of a member before any treatment for a distinct level of care has been delivered. Prospective review is conducted for all non-emergency mental health treatment for inpatient and sub-acute/respite admissions. JBH has contracted for most in-patient hospital and sub-acute crisis resolution services to be all inclusive of all necessary mental health services. Additional or adjunct services provided during the period of admission to an inpatient hospital or sub-acute facility which is not contracted for all inclusive per diem rates, are also subject to prospective review.

Prospective review activities may be completed on site or telephonically. When a member is admitted to an acute care facility in a true clinical emergency, JBH does require a preauthorization referral by the member's local County Mental Health Program crisis service which can be contacted through the local CMHP Crisis Line.

All admissions to acute or sub-acute care settings will be reviewed by the standards in section 1 for inpatient and sub-acute admissions. The primary route to admission is through the member's local County Crisis Service with the JBH Utilization Manager only as a backup or to confirm benefits are available and authorized. Any admission not pre-screened by the member's local County Crisis Service will be referred back to them by the JBH Utilization Manager for a referral. Should there be disagreement between the screening hospital and the local County Crisis Service then the JBH Utilization Manager and Consulting Physician can be brought in for a Second Level Prospective Review.

First Level Prospective Review for Acute and Sub-Acute Care

When providers or facilities call to request prospective authorization for a non-emergency inpatient or sub-acute/respite admission, they are connected to the JBH Utilization Manager for completion of a clinical review. During a clinical review the Utilization Manager:

1) Gathers comprehensive clinical data from the provider/facility. Requests for information will be limited to the information that is pertinent to rendering a utilization management decision and managing care

2) Verifies and substantiates a covered 5 axis diagnosis per current DSM IV TR criteria and the legislatively approved list of covered diagnoses.

3) Reviews physician certification of necessity and psychiatric intake assessment.

4) Reviews the proposed treatment plan which:
   a) integrates measurable goals and objectives
   b) is individualized to address the specific problems presented by the member at admission
   c) contains an individualized plan for the involvement of family members unless therapeutically contraindicated
   d) includes a comprehensive, individualized discharge plan.

5) Utilizes JBH review criteria in section 1 to determine if the proposed care is needed and when indicated, makes use of network (or non-network providers if clinically appropriate) to refer the member to a less restrictive level of care.
6) Determines the number of days to certify. If unable to approve the provider's request, refers the case to the JBH Medical Director for second level review.

Second Level Prospective Review

When the JBH Utilization Manager is unable to authorize a request for care, the case is referred to the JBH Medical Director for a second level review. During a second level review, the Medical Director:

1) Reviews all available clinical materials

2) If additional clinical information is needed, the case will be discussed directly with the attending physician or other providers of care who have been recently involved in either evaluating or providing services to the member and can reasonably be expected to have clinical knowledge that will be helpful to making a decision regarding appropriate certification of care and treatment planning.

3) Makes and documents a pre-certification decision and refers the case back to the JBH Utilization Manager for follow-up.

Section VIII Inpatient & Continued Stay Review Criteria

ACUTE CARE

Review Criteria

Inpatient treatment is typically Hospital based services that provide 24-hour medically managed care and monitoring. This level of care is secure with the ability to provide seclusion and restraint. Inpatient treatment is indicated when it is determined to meet inpatient admission or continued stay criteria and it is determined that inpatient hospital treatment is the most effective and adequate to manage the members covered psychiatric condition in the least intrusive and least restrictive manner available based on review of additional JBH criteria for medical necessity.

When a member is hospitalized coordination will occur between the hospital, JBH Utilization Manager and the local CMHP staff to resolve the crisis and move the member to a less restrictive level of care as soon as possible.

Inpatient psychiatric care should be used to treat a mentally ill person who requires a 24 hour (round the clock), medically structured and supervised facility. JBH criteria for admission and continued stay at an inpatient facility assume that the member's illness is so severe that alternative treatment (sub acute, respite, or outpatient treatment) would be unsafe or ineffective.

Continued Stay review is an evaluation of:

1) A member's continued need for treatment
2) The appropriateness of the current and proposed treatment
3) The appropriateness of the setting in which the treatment is being rendered or proposed

Continued Stay Criteria

Following an authorized admission, the member's provider must call the JBH Utilization Manager or the local CMHP staff designated by JBH to receive utilization management information within one business day. The first continued stay review is initiated and completed within one business day of admission. The JBH Utilization Manager or the local CMHP staff designated by JBH to receive utilization management information and provider discuss the initial treatment plan, goals of treatment, and the initial discharge plan. Additional days are authorized as necessary. Continued Stay Reviews are completed throughout the authorization time frame, at intervals deemed clinically appropriate and necessary by the JBH Utilization Manager. Such

deemed intervals are based on the clinical presentation and ongoing treatment needs of the member during the episode of care. The JBH Utilization Manager or the local CMHP staff designated by JBH will notify the provider of the dates of the Continued Stay reviews.

1) Member must meet all of the following criteria for continued stay:
   a) Member continues to require active symptom management and requires medically managed 24-hour care that is not available at a lesser level of care.
   b) Member continues to show improvement but has not achieved a degree of clinical stability which would warrant discharge to a lesser level of care.
   c) An individualized discharge/ transfer plan has been developed which includes active coordination with aftercare mental health providers, coordination with health and social service providers, and coordination with member's informal support system. The plan is realistic and includes a date and place for discharge to occur.
   d) The current treatment plan is appropriate to treat the member's illness and is expected to result in symptom stabilization and a return to baseline in Member's symptom level and functioning or transfer to long term care.

All continued stay review activities are completed by the JBH Utilization Manager who may chose from the following methods to conduct their review activities:

Telephonic Continued Stay Review

Information is generally gathered either from the provider directly involved in rendering services to the member, or the UR staff at a facility.

On-site Clinical Review

In locations where JBH has contracted with local providers for this service, continued stay reviews of facility-based treatment may be completed on-site in order to obtain first-hand clinical data.

Such reviews are generally conducted when the member:

1) Has a highly complex clinical presentation
2) Has a history of readmissions, or
3) Is being treated in a facility for an extended period without measurable progress

On-site review may include a review of all pertinent medical records, discussion of the case with the treatment team and/or a face-to-face meeting with the member and/or family.

Medical Chart Review

JBH may request the attending provider or facility utilization review staff send some or all of the member's medical record via facsimile or overnight express mail. This information will be used to review and/or validate the report of the member's condition and clinical progress. The chart may be requested when:

1) The Utilization Manager is provided conflicting data regarding the continued clinical need and appropriateness for the current level of care, e.g., despite a description of continuing suicidal behavior, a member is allowed a weekend pass with a family member.
2) The diagnosis is not supported by information reported during telephonic review.
3) The treatment plan seems inappropriate for the clinical presentation of the member, e.g., the member is experiencing visual and auditory hallucinations, yet no medications are considered or prescribed.

Clinical data furnished by the provider is insufficient and does not permit the reviewer to make a well-informed decision.

SUB-ACUTE CARE

Sub-Acute Review Criteria

Sub-acute treatment is typically facility based services that provide 24-hour supervision and support in a secure or non-secure crisis resolution facility. Crisis resolution centers are contracted to provide different levels of care based on their ability to be licensed to provide secured treatment, seclusion and restraint, non-hospital holds, and other considerations. Some facilities provide secure treatment as well as respite care options. Sub-acute care is indicated when it is determined to meet sub-acute admission or continued stay criteria and is the most effective and adequate treatment to manage the member's covered psychiatric condition in the least intrusive and least restrictive manner available based on review of additional JBH criteria for medical necessity.

Sub-Acute care should be used to treat a mentally ill person who requires a 24-hour (round the clock), structured and supervised facility. JBH criteria for admission and continued stay at a sub-acute facility assume that the member's illness is so severe that alternative treatment (respite, or outpatient treatment) would be unsafe or ineffective. The JBH utilization manger:

1) Gathers comprehensive clinical data from the provider/facility.
2) requests for information will be limited to the information that is pertinent to rendering a utilization management decision and managing care.
3) Re-verifies and substantiates the diagnosis per DSM IV TR criteria

4) Reviews progress made in relation to all active treatment goals included in the master treatment plan, discusses goals added to the treatment plan and also discusses appropriate level of care required to treat remaining problems.
5) Identifies and investigates possible quality of care concerns.
6) When appropriate, reviews progress made in family treatment and evaluates indicators for continued intervention.
7) Discusses discharge plans, timelines and possible obstacles to successful implementation.
8) Utilizes review criteria to determine clinical need and appropriateness for continued stay.
9) Makes determination of number of additional days to certify. If unable to certify further days, refers to Medical Director for second level review.

Sub-Acute Care Continued Stay Criteria

2) Member must meet all of the following criteria for continued stay;
   a) Member continues to require active symptom management and requires supervised and supportive 24 hour care that is not available at a lesser level of care.
   b) Member continues to show improvement but has not achieved a degree of clinical stability which would warrant discharge to a lesser level of care.
   c) An individualized discharge/ transfer plan has been developed which includes active coordination with aftercare mental health providers, coordination with health and social service providers, and coordination with member's informal support system. The plan is realistic and includes a date and place for discharge to occur.
   d) The current treatment plan is appropriate to treat the member's illness and is expected to result in symptom stabilization and a return to baseline in Member's level of symptomatology and functioning.

Section IX Discharge Planning & Criteria

Discharge Planning

Discharge planning is an essential component of JBH's utilization management program. It is a process which focuses on facilitating appropriate and timely discharge from facility-based treatment and ensures that members are linked to comprehensive aftercare services.

JBH's clinical review standards require that discharge planning activities be documented during the first review of a case and be monitored closely during subsequent reviews throughout the treatment episode. Upon initial pre-certification, the Utilization Manager clarifies the anticipated length of stay and criteria for discharge.

Discharge Criteria

1) Members meeting one of the following criteria shall be determined to no longer meet hospital level of care criteria:
   a) Absence of imminent danger to self or others.
   b) Discharge/transfer plan ready for implementation with a realistic plan for aftercare.
   c) Member is clinically stable to transition to a less restrictive level of care.
   d) Maximum clinical benefit has been achieved and it appears unlikely that further clinical benefit is possible.
   e) Member meets criteria for transfer to Long Term Psychiatric Care.
   f) Member and/or family have established a pattern of noncompliance with treatment plan, including treatment recommendations for family involvement and State criteria for an involuntary hold or commitment are not met.

Section X Retrospective Reviews

JBH conducts retrospective reviews of inpatient care to evaluate care which has already been delivered including emergency care. The purpose of this type of review is to determine if such services were clinically needed and appropriate, prior to releasing any or part of the claim payment requested.

When an inpatient, crisis respite or residential respite claim that was not preauthorized by County Crisis Service staff is received:

1) The JBH Utilization Managers will pend claims which are eligible for retrospective review and will notify the provider/facility of which records are required to complete a prepayment review for clinical need and appropriateness.
2) When all records required for the review have been received, the JBH Utilization Manager:
   a) Completes a clinical review of the record utilizing JBH level of care guidelines.
   b) Makes a first level review decision, authorizing all, part or none of the treatment episode
   c) Documents the results of the review

If the first level review does not support clinical need and appropriateness for any or all of the facility stay the case is forwarded for review by a JBH Medical Director. If the second level reviewer issues a determination to deny any or all of the care, the member, provider and facility are notified in writing and informed of the appeal process. A final determination is issued on all prepayment reviews within 30 days of receipt of all necessary clinical materials.

Section XI Denials and Appeals

Acute Care Denials, Appeals, and Consultation with Providers during the review process.

The JBH Utilization Manager conducts all first level review activities using JBH Inpatient Review Criteria and Service Authorization Decision Criteria. All cases not approved as meeting the review criteria are submitted for second level review.

All second level reviewers are clinical psychiatrists. All second level reviews are conducted to render clinical need and appropriateness decisions based on the JBH criteria and medical expertise of the reviewer.

1) If the appropriateness of type or level of care is questioned and a potential denial of benefit may be indicated, the case is presented by the JBH Utilization Manager to the JBH Medical Director within one business day of receipt of all necessary documentation and /or all pertinent clinical data. At that time, a physician to physician consult will be offered by the Utilization Manager to the treating physician.

    a) If an authorization cannot be supported by the Medical Director, based on that conversation, that decision will be conveyed by the Medical Director to the treating physician at that time. Once the denial has been conveyed to the treating facility MD, the JBH Medical Director will then immediately notify the JBH utilization manager, at which time she/or he will generate a Notice of Action (NOA) letter, which will be mailed to the facility and the member .

2) If a denial is made by the Medical Director, the JBH Utilization Manager will send the NOA letter to the member and/or the facility within one business day, indicating the reason for the determination and how to initiate reconsideration or appeal. The NOA also informs the member how to file a grievance, an appeal, and describes how to request an Administrative Hearing.
    a) The letter is signed by both the JBH Utilization Manager and the JBH Medical Director. The JBH Utilization Manager may sign the denial letter for the Medical Director when directed to do so by the Medical Director.

3) If the provider requests an expedited appeal of the denial, he/she may request a second level phone review by the JBH Medical Director or designee within one business day. If the denial is upheld, a letter is written by the JBH Medical Director and signed by both the JBH Utilization Manager and the JBH Medical Director. **The JBH Utilization Manager**

may sign the denial letter for the JBH Medical Director when directed to do so by the Medical Director. The letter is to be sent to the member and facility within one business day, indicating the reason for determination. No further appeals within JBH are available if the facility requests an expedited appeal. However, the member has the right to request an administrative hearing as indicated in the NOA as issued and described above. The option for an expedited appeal is limited to prospective and continued stay review authorizations.

4) A final level of appeal is possible, if requested, through the JBH Utilization Management Appeals Subcommittee. The provider or member may request such a review through the Utilization Manager. This review is completed within 30 calendar days of receipt of requested documentation. If the denial is upheld by the Appeals Subcommittee, the Subcommittee Chair completes and signs the Denial of Authorization forms and sends them to the member and provider within two business days, indicating the reason for the determination.

5) An appeal is also available, for members, through AMH. This appeal needs to be filed within 30 calendar days of the receipt of the Notice of Action form. The process for requesting a hearing is included in the mailing with the Notice of Action.

Jefferson Behavioral Health Eligibility for Indigent Care

Fax first page to Ph Tech at (503) 566-9801

Agency determining eligibility for level of care

Referring County Provider Agency:_____________
Location:______________________________

Intended Delivering Provider:
__Inpatient Hospital________________________ CRC______________________________
(Name) (Name)
__ JBH Contracted Respite Facility ____
(Name)
Date eligibility determination initiated by County Program______________________

Client Information

Last Name: ________________ First Name:________________ M.I.:______
Mailing Address: ____
(JBH County)
DOB: _____________________________ SSN: _____________________
Primary Diagnosis I: ______________ LOCUS/CASII Score: ____________
(if applicable)
Secondary Diagnosis II: _________________

Legal Status

__ Committed __ Emergency Hold __ Vol. Diversion
__ Outpatient Commitment
__ Vol. Admission (with JBH UM approval and meets diversion from hold or commitment criteria)

Possible other payers in line before JBH

__ OHP #: ___________________________ __ Medicare #: ______________________________
__Other private insurance _______________ Plan:_____________________
ID:_____________________

JBH Indigent Criteria: (must meet all of the criteria listed below)

- __ JBH county mailing address
- __ Monthly income verified as meeting the current JBH criteria*
- __ No insurance or significantly underinsured (i.e. insurance benefit is exhausted or inadequate to provide the basic services needed to be successfully maintained)
- __ Has no current "prepaid" service authorization
- __ Cannot be adequately served by other community services (free or low cost counseling or healthcare, primary healthcare clinics, substance abuse treatment programs, etc.)

Submitted By:____ Date: _______________