AWHP
ASSOCIATION OF WASHINGTON
HEALTHCARE PLANS

August 24, 2018

Summary of Carrier Responses to Informal OIC Survey: Admissions for Inpatient Mental Health Treatment

1. What do you use for determining the standard of care for inpatient mental health treatment? (Examples: Milliman, CareWeb)

   Carriers use nationally-recognized, evidence-based sets of criteria to decide if inpatient and residential mental health and substance use disorder treatments are medically necessary.

   Evidence Based Care Guidelines: Carriers develop their medical criteria using a combination of or a single source from the following:

   BCBSA Medical Policy Reference Manual
   BCBSA Technology Evaluation Center Assessments and other national sources of technology assessments (including AHRQ)
   Hayes, Inc. (Knowledge Center and Technology Assessment Services)
   Published, credible scientific evidence in peer-reviewed medical literature
   Milliman Care Guidelines
   National guidelines developed by medical specialty organizations
   Independent external advisory groups
   Practicing physician input
   Independent Review Organization materials
   McKesson InterQual Behavioral Health criteria for mental health diagnoses
   American Society of Addiction Medicine Criteria alone or with an overlay of other criteria for SUD regarding medical necessity determinations

   Carriers also use the clinical expertise of practicing physicians who participate in a carrier's Pharmacy and Therapeutics Committee, Oncology Advisory Panel, as well as regional physician advisory committees, and contracted local practitioners.

   The entities used have created evidence-based care guidelines based on peer-reviewed papers, research studies that are consistent with evidence-based medicine across several specialties, including behavioral health. All criteria used are based on evidence-based treatment and clinical standards of care. The organizations review and update criteria at least annually by appropriately licensed personnel.

   Timing of Authorization and Reviews: Clinical priority and level of care determines the timing of authorization and reviews. All acute inpatient psychiatric patients are authorized initially until the next business day, when an assessment and diagnosis must be completed and shared with the carrier. Non-acute inpatient admissions are typically required to be authorized in advance with the carrier; if a facility admits a member without obtaining prior authorization and the facility is in network, the member is held

harmless for the cost of care and by contract, should not be balance billed for the denied claim.

Mental health utilization review staff conduct concurrent review every 1-5 days, depending on the condition or treatment plan, until discharge to ensure ongoing medical necessity for the treatment being provided for the member's condition. The frequency of concurrent review depends on the type of treatment being provided, as well as the type of facility. The requirements may also differ based on the age of the member, as some quality criteria require higher levels of care or different treatment approaches for a condition experienced by child or adolescent.

2. Do you use a benefit manager to determine such admissions?

   The majority of plans do not use a benefit manager.

3. What criteria do you OR your benefit manager, use for continued stay review?

   The same criteria for admission, based on the reported condition of the patient at the time of assessment.

4. Do you require prior authorization prior to a patient being admitted?

   If a patient is admitted on an 'urgent basis' to an inpatient facility, carriers require notification of admission within 24 hours followed by concurrent review.

   Non-urgent or emergency admissions do require prior authorization to a facility to admit the member. The period for processing a prior authorization for non-urgent admission is typically between 1-5 days, depending on the clinical urgency of the member's condition. Admission for non-urgent care is also affected by a facility's bed availability and transfer.

5. What is the time frame from request to being admitted?

   Please see answers above.

6. Is there a standard minimum length of stay for inpatient mental health treatment?

   No.

   a. How is total length of stay determined?

   The length of stay for inpatient mental health treatment is based on the clinical needs of a patient using the review criteria outlined in previous questions. After the initial authorization of inpatient mental health coverage, coverage of the inpatient mental health treatment is subject to concurrent review. Discharge planning occurs as part of this process, using concurrent clinical information .

   b. Is there a maximum inpatient authorization?

No.

7. What differences, if any, are there in your admissions and review practices when the inpatient treatment comes about via PIT?

   There are no differences. Frequently, consistent with Washington state law related to minor consent for mental health treatment, parents are involved in the decision to admit their child to inpatient mental health treatment when they feel their child is at risk of harm to themselves or others. In order for inpatient mental health treatment to be covered by a minor's health plan, regardless of whether the treatment was initiated by the minor's parent, the minor, or by a designated crisis responder under Washington's Involuntary Treatment Act, the services must be medically necessary based on the carrier's clinical criteria described above. There are no differences in the prior authorization or concurrent review processes or clinical criteria between inpatient mental health treatment that is initiated by a minor's parent and any other inpatient mental health services. Parents who disagree with a coverage decision may appeal the decision through an appeal.

   a. What is the process for determining post-inpatient treatment release?

      Carriers coordinate with the discharging facility to develop a plan for treatment for the patient in coordination with a multidisciplinary team. The plan for treatment varies based on the clinical needs of the individual and focuses on guiding the patient to the next most appropriate level of care. Typically, patients receive follow up within 7 days of release, and again at 30-days post discharge.

   b. What post-inpatient treatment options do you approve?

      Post-inpatient treatment plans may include outpatient mental health services, intensive outpatient mental health services and medication management. The discharging facility, carrier and patient support teams work together to coordinate the post-inpatient treatment plan. Care Planning and Evaluation guidelines are used, based on the criteria used by a carrier from the list of evidence-based sources identified in the answer to question one.

   c. What criteria are used to determine what will be approved?

      The criteria don't differ for post-discharge services: the medical needs of the member are used to assess a proposed treatment plan for approval, using the nationally recognized, evidence-based guidelines adopted by the carrier for use.

8. What do you see as role in terms of quality and oversight of PIT treatment providers?

   Carriers don't administer the inpatient benefit using a category labeled PIT treatment provider. Carriers establish credentialing criteria for in-patient treatment facilities, and

quality is an important component of the credentialing process used by health carriers. It is appropriate to monitor a provider's performance between credentialing cycles to ensure quality and safety of care and to make appropriate interventions. Typical criteria include current licensure, general liability coverage and malpractice insurance as required by state law and the carrier's standards, eligibility to participate in Medicaid or Medicare programs, appropriate accreditation or a satisfactory alternative by a recognized accreditation entity. Some carriers use a site visit as an alternative to accreditation.