Insurer survey Questions

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

   <u>For BHOs</u>: *Per the PIHP contract, BHOs must maintain and follow written policies and procedures for authorization of behavioral health services including: 6.2.5. Criteria for Authorization of Routine and Inpatient care at a community psychiatric hospital.*

   The criteria used may vary by BHO but are likely to rely on tools such as the Milliman Care Guidelines, Locus/Calocus, and so forth.

   <u>For MCOs</u>: *The MCOs also use criteria that is similar. It varies by MCO but typically are these: MCG, Locus/Calocus, InterQual, and American Society of Addiction Medicine (ASAM).*

2) Are there diagnoses/circumstances that have different time frames? If so, what are they and why?

   <u>For BHOs</u>: *Diagnoses do not trigger different timeframes, but specific circumstances do.*

   Emergency services and post-stabilization services follow the time frames of 42 CFR 438.114:

   - *Authorization is not required to render emergency related stabilizing care to the point of stabilization for discharge or transfer.*

   - *Post-stabilization services require response from the BHO for services within 1 hour of provider request. And the Provider can assume authorization if the plan does not respond within the hour up until the point that contact is made.*

   Non-emergency inpatient services/planned admission follow the requirements of 42 CFR 438.210:

   - *For inpatient services the PIHP contracts require authorization decisions to be made as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.*

   <u>For MCOs</u>: *Diagnoses do not trigger different timeframes, but specific circumstances do.*

   MCOs do not authorize emergency or post-stabilization services. They require notification of the admission and require authorization for the continued stay. They do require authorization for planned inpatient or acute care stays.

   Timeframes for their response differs depending on the urgency of the situation: A request for an urgent admission must be decided no later than 72 hours after receipt of the request for service. A request for a standard (non-urgent) admission must be decided by 5 days after receipt of the request.

3) Do you use a benefit manager to determine such admissions?

   <u>For BHOs</u>: *Varies by BHO*
   <u>For MCOs</u>: *Varies by MCO*

4) What criteria do you OR your benefit manager, use for continued stay review?

   <u>For BHOs</u>: *Varies by BHO*

<u>For MCOs</u>*: Same as the answer to question #1. The benefit manager must use the same criteria as the MCO.*

5) Do you require prior authorization prior to a patient being admitted?

<u>For BHOs</u>*: Treatment of unstabilized emergency medical conditions do not require prior authorization. Post-stabilization services require prior-authorization but follow the rules of 42 CFR 422.113(c).*

- *1hr BHO response or authorization assumed until the plan makes contact*
- *BHOs are obligated to pay for post stabilization services they have not authorized until*
  - *A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;*
  - *(ii) A plan physician assumes responsibility for the enrollee's care through transfer;*
  - *A BHO representative and the treating physician reach an agreement concerning the enrollee's care; or*
  - *(iv) The enrollee is discharged.*

Non-emergency/Planned admissions follow the rules of 42 CFR 438.210 which permits the PIHP to place appropriate limits on a service. Prior authorization may be required.

<u>For MCOs</u>*: Emergency? No authorization is required. Notification only.*

Voluntary Planned Admission? Yes, MCOs may require authorization.

6) What is the time frame from request to being admitted?

<u>For BHOs</u>*: Emergency inpatient services do not require prior approval.*
BHOs have up to 1hr to approve post-stabilization services related to an emergency.

Non/Emergency / Planned admissions follow the timelines present in 42 CFR 438.210

<u>For MCOs</u>*: Emergency? n/a as no authorization is required.*

Voluntary Planned Admission? Urgent Situation: 72 hours or as soon as the client's condition warrants

Voluntary Planned Admission? Standard (Non-Urgent Situation): 5 days or as soon as the client's condition warrants

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

<u>For BHOs</u>*: No.*

<u>For MCOs</u>*: No. Length of stay is based on individual need*

b. How is total length of stay determined?

<u>For BHOs</u>*: Should be determined by the treating physician in consultation with the plan. Any denial must be reviewed by the plan's medical director.*

<u>For MCOs</u>*: No. Length of stay is based on the client's clinical need and medical necessity. The Utilization Management criteria (listed in Question #1) as a guide to assist in decision-making.*

c. Is there a maximum inpatient authorization?

<u>For BHOs</u>*: No*

For MCOs*: No.*

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

For BHOs*: No difference*

For MCOs*: No difference*

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

For BHOs*: Consultation between plan and hospital*

For MCOs*: Consultation between plan and hospital*

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

For BHOs*: The range of services covered by the 18 State Plan Modalities provided by BHOs:*
For MCOs*: same*

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

For BHOs*: Guidelines developed by the BHO for rehabilitative services.*
For MCOs*: Service must be medically necessary. If MCO authorizes service (intensive BH services only) then, utilization management criteria are used. If no authorization is required, the provider's judgment is used to determine if the service is appropriate.*

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

Depends on the contractual relationship of the provider. Limited for services furnished under the HCA Medicaid Core Provider Agreement, Greater for those with a direct contract relationship.