# PIT Advisory Breakout Workgroup – Admission Practices

Monday July 16, 2018

10:00am-12:00pm

Attendees:

Lonnie Johns-Brown, Kathy Brewer, Brad Forbes, Melanie Smith, Lisa Daniels, LaRessa Fourre, Amanda Lewis, Diana Cockrell, David Johnson, Lois Williams, Blake Ellison, Kalen Roy, Peggy Dolane, Evelyn Maddox, Danielle Cannon, Kevin Black -- On the phone: Danielle Cannon, Kalen Roy, Peggy Dolane

## Parameters of the breakout workgroup on admission practices

The goal of the workgroup is to obtain factual information about what hospitals and insurance companies are doing in terms of medical necessity and admission practices. The focus is on hospital acute care, residential treatment and long term care, rather than the access, avenue to outpatient treatment. A suggestion was made to look at it more broadly than a residential setting, however, for this meeting, we will maintain the focus mentioned above and bring the opportunity for a more broad discussion in the age of consent meeting later today. It was also mentioned, as a parent, the importance of looking at the whole continuum in regards to admission practices and not just residential treatment. We can be sure and pose the concerns raised in other workgroups for further discussion.

## Review state definition of "medical necessity" and the surrounding laws

It was stated that the state law is not too particularly detailed. Standards are posted online and companies look to national groups for guidance. The Office of Insurance Commissioner (OIC) identify standards on their website, which also show number of denials, but do not detail medical diagnosis, i.e. cancer, diabetes, etc. The information offered is a high overview. There is no uniformity, and consistency across health care plans. We want to know more about who and where the plans are looking to for guidance. Insurance plans should be updating their webpages to comply with statute that was made effective earlier this year; RCW 48.43.016. If the Medicaid system has specific requirements, contractually the plans are bound by this. Does Medicaid do anything more? We would like to look into both to compare. A stakeholder mentioned the Service Encounter Reporting Instructions (SERI), which is the Medicaid reporting and billing guide. There still can be interpretation differences among Behavioral Health Organizations (BHOs) when reporting service encounters.

Revised Code of Washington (RCW) 71.34, Mental Health Services for Minors defines medical necessity in the Parent Initiated Treatment (PIT) section. A stakeholder recommended developing a crosswalk defining medical necessity in the RCW as it relates to PIT and Title 48, which constitutes insurance plans. Kathy B. volunteered to take this on, completing it by 7/23. If appropriate the next layer would be to look at Children's Long-term Inpatient Program (CLIP). Clarification was asked as to the detail, and reasoning of adding CLIP information. The determination was made to not include CLIP in the crosswalk.

At Seattle Children's, medical necessity review is between 7-14 days. SUD PIT has been assigned to CLIP as the state authority and oversight, however there is no direct connection with the CLIP Admin. Not acute hospital in design. It is a different level of care than PIT. CLIP is both involuntary and voluntary. Recognizing it is a different process, and PIT is not a pathway to CLIP. Committee member stated kids who would be better fit via Involuntary Treatment Act (ITA), coordinated with parents, and would like to hear their experiences. Designated Crisis Responder (DCR) in ER told them they had to do PIT. Less restrictive option. Information was shared with parent on how to communicate with DCR. This has been occurring a lot with conducting reviews. Committee member doesn't want to create confusion including CLIP in the conversation and that this is something the larger workgroup could decide. The question was posed, should there be a pathway for PIT to CLIP?

It had been reported previously that they have received 1, 2 PIT patients. Committee member stated that if a child is under PIT status, and they are due to be discharged, they can enter CLIP if their status is changed and they are put on a 180 day order via ITA, or if they go voluntarily they will be added to the waitlist. There is a door there for youth to enter CLIP on a PIT, however it does not happen very often. A suggestion was made to bring to the larger workgroup, and that would be to develop a one page information sheet to identify differences between PIT and CLIP.

CLIP can admit children who have private insurance into the state system, however the only option is via ITA. This allows parents access to crisis stabilization.

## Review of survey

Insurance plans are regulated by OIC being guided by The Employee Retirement Income Security Act of 1974 (ERISA) that sets minimum standards for health plans in the private industry to provide protection for individuals in these plans. A next step could be to gather information from the insurance plans and regulated commercial market only, or do we want to ask the plans to respond with what they do as part of ERISA, which is not regulated by Health Care Authority (HCA). There is Medicaid, commercial market and then a self-funded market. OIC only regulates specific plans, the others are regulated by the dept. of Labor. Some stakeholders did mention the complexity of this and suggested writing a description in this area to better understand the complications of this area.

If there are areas we don't regulate, and still acquire information, what could we do with the information gathered? A suggestion was made to stick to the areas we can control, including Medicaid, and the commercial market, that OIC regulates. Committee member stated perhaps posing the question "do you have coverage?" and thought it would be interesting to know at least, even though we don't regulate them, we regulate the certified behavioral health providers, as well as asking if folks are aware of specific commercial plans.

Committee member mentioned she works with a variety of payers and haven't identified many differences. They appear to function the same in her experience. We know they use medical criteria, but we want to learn more about where the guidance came from, and what is it based on? What are you using for this? Pairweb? This allows us to access each of those. Most plans don't make up their own, they use a tool already developed.

Committee member stated a lot of commercial plans use benefit managers to assist in the management of prior authorizations for care, and the continuation of stay, rather than having an in-house staff person. Others mentioned the contact information you are given for your plan to inquire about services, and if services are needed, there is a prior authorization process, and at that time you'd be talking to the benefit

manager. This may be an area where it would be important to ask questions like the following: Do you use a benefit manager? If yes, when contracting them, what information is shared with them? How can we learn more about how the benefit manager(s) interpret admission practices, and continued stay reviews? What things are triggering reviews? Is there room for state law here with the benefit manager? Can we go in and make a medical necessity statute change?

Committee member posed the question and if we should inquire about network adequacy? The commercial market is required to report this to Lonnie on a monthly basis. Although this information is reported monthly, network adequacy is always changing.

Committee member asked, how is a parent able to appeal an insurance denial as it relates to medical necessity when they are not able to access their child's medical information, especially when they have diagnoses such as oppositional defiant disorder (ODD)? Additionally, what is serious enough if a parent feels it has risen to the level of need for inpatient treatment and that it is not being approved? When least restrictive alternative (LRA) is mentioned, what are the services that fall under that? If your insurance says that intensive treatment is a part of your plan, however no one in the area offers this service, will the same treatment service be paid for outside the area in which you reside? How do you manage an appeal? This last question should be brought back to the larger group to discuss.

Treatment, and determining appropriate length of stay, one thing that has been followed is if you can provide treatment in a LRA, but there are not providers in your area, what guidance is given to parents on what they should do? The concern is if an identified service is not able to be provided in the area where the youth resides, what other options does the insurance company offer? If residential treatment does not get authorized, does another level of care get authorized? Also, how is LRA defined, and what standards govern this? What other services are offered if acute hospitalization is not authorized? When you receive a denial, what additional information do you receive?

Perhaps adding a question in the provider survey if they've ever had a situation where a claim was denied because they couldn't release adequate records. It is allowable for the provider to share confidential info with the insurance company. Has this ever caused concern or problems in the past?

Timeliness – what is a reasonable admission time from request to being admitted? The need for pre-authorization, encountering barriers with insurance that may include legal aspects adds wait time, if folks are experiencing challenges such as this. How long should parents anticipate waiting? Is there a different standard that rises to a higher level of urgency, and what is the standard for that?

Community member asked about how long authorizations are good for? Stakeholders stated 1 day, 4 days, there's quite a bit of variation. The level of acuity plays a role in the variation. Additional questions were: Is there a standard minimum? How do you determine total length? What is the maximum? The max number of authorization days is 44. Seattle Children's average length of stay is 6-7 days and the initial auth can be 3-5 day, some auth 1 day and then do a continued stay the following day. It really varies. Some don't require pre auth, continued stay, and will review medical records after the fact.

Practice in some cases in the past you could admit a youth in substance use disorder residential treatment without prior auth, notifying the plan a day or two after admission, and this tended to be an easier process. Should the practice here be similar, not putting hurdles up front, and make requirements once the youth is admitted? This is how it works from the commercial market perspective. Some BHOs require prior authorization, some do not. At Children's they have adjusted their processes with how the world is currently working will all involved. They tend to ask for 3-5 days at a time because this is typically what they would auth for. Longer lengths of stay requests had a tendency to not be approved. Are there different standards

for acute SUD, in terms of length of stay? Or lengths of stay for particular diagnoses? Spokane BHO stated they follow ASAM, where there is not a blanket length of stay or level of care, and that it is designed to be individualized. They see that authorizations tend to be about 15 days, however it is reviewed on a case by case basis. Should an authorization be longer for the PIT process? What really is appropriate based on diagnosis, and what else is available to them?

Excelsior, no standard tool, person centered recovery planning

Any national group that has talked about standard of care and range of diagnosis?

Community member stated when she was at the BHO they looked nationally to see if there were any standardized tool.

Patient health questionnaire PHQ9

North Sound BHO, and King County BHO use the Child and Adolescent Level of Care Utilization System (CALOCUS) – Kathy offered to share this tool with the group.

Later on asking providers if they've heard of other tools

Question for hospital – how often does it occur that the medical determination is not agree upon by both parties? Do they discharge? Are they successful when they appeal? Looking at plans and BHOs because they do this differently. From a clinician's perspective, it is really challenging and difficult conversation to have with a parent. Education, and what is reasonable to expect from an acute hospital, and other system resources. How often do hospitals refer to WISe? Residential treatment? And what identified barriers have there been?

It was asked when the payer is ready to discharge, but the hospital is not, what happens next? If the hospital decides to keep the child admitted the hospital is received an extremely low reimbursement rate because they don't feel it is medically necessary to discharge. Does Children's accept advent days? Yes, it is $208.

A question was asked, how do you resolve issues when there are disagreements with the payer? For commercial plans, a patient or advocate can call the line directly, which is a staffed consumer advocacy program. If admission and medical charts are reviewed after an individual enters treatment, there is also the independent review org. It is a lengthy process, but has a good success rate. This will not be helpful on the weekend, however. If your plan has a benefit and if you think it's not being applied, you have the right for an OIC staff person to advocate on your behalf. If you have a parent, as well as a provider advocating, the plans can help to intervene. Have providers received support from OIC. This is always a case by case basis.

For the part of the market that is not regulated, does OIC investigate complaints? Lonnie stated yes, however a response from the insurance plan is optional.

What do insurance companies think their role is in terms of quality and oversight? Qualifications, legitimate treatment, meeting standards. The plans contract with licensed providers, and they want to be sure individuals are receiving the services they have contracted for. They certainly want to know if services are being provided and are of quality and that standards are being met.

## Topics for next meeting – Date: August 24, 2018 – Time 1:00pm-3:00pm

Lonnie summarized as the meeting came to a close that we will be gathering everything discussed and delegated and share with the group. We asked if stakeholders could review the questions and decide if we feel the questions are appropriate as well as indicate where there is overlap, if any. The goal is to not have more than 20 questions, having them finalized and out early next week. If time allows, edits will be made if

needed. Lonnie will send out the questionnaire, and also determine the deadline in which it must be completed by. Lonnie anticipates giving plans about 4 weeks to respond, being sensitive to other requirements and work occurring at this time.

Paul asked if the plans will answer the questions that we develop or if there would be hesitancy to answer honestly. Lonnie stated they plan to preview the questions to determine if any will be hard to answer and if so, perhaps reword them.

Meeting adjourned: 11:40am

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